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AN ANALYSIS OF CONTINUITY OF CARE IN
A COMMUNITY MENTAL HEALTH CENTER

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
John Thomas Byrd, III, B.A., M.S.S.W.

* * * * *

The Ohio State University
1972

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CHAPTER I

PROBLEM AND PURPOSE
Introduction

The concept of community mental health reached the legislative stage in Congress in 1963. The major intent of this legislation was to stimulate and aid communities in providing comprehensive psychiatric services to people near their residence and that the care given be appropriate and of the utmost quality. Continuity of care, a concept used in the legislation, was spelled out as a major program goal. Thus, in any evaluation of community mental health centers, continuity of care must be scrutinized.

Two fundamental questions constitute the core of this investigation. They are: (1) what are the dimensions of the concept of continuity of care as it relates to and has meaning for comprehensive community mental health centers, and (2) to what extent does the Barren River Comprehensive Care Center facilitate and achieve continuity of care?

The Joint Commission on Mental Illness and Health, who defined the planning task for increasing the quality of mental patient care, was confronted with reconceptualizing

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the problem and proposing a potential restructuring of institutional arrangements to meet mental health needs in a more adequate manner. Their proposal for better institutional care and newer approaches led to the Community Mental Health Centers Act of 1963. The major intent of the community mental health legislation is to prevent people from being socially isolated when they have mental and emotional problems and to restore those hospitalized to their communities as quickly as possible. Enhancing the client's social functioning is a difficult and demanding task, and one that necessitates continuity of care throughout the therapeutic process. In an attempt to realize this objective it became necessary for community mental health centers, if they were to receive federal support, to provide a full range of comprehensive services for identified psychiatric patients. The minimal amount of services viewed as comprehensive consist of five essential service elements: namely, community based emergency care, inpatient and outpatient psychiatric treatment, partial hospitalization, and consultation and education services to the community at large. The notion of comprehensiveness of


service elements represents a cross-sectional view of the amount and type of services. Continuity of care on the other hand, recognizes the longitudinal dimension. Continuity of care takes place within the context of comprehensive service elements. However, if a service element is needed by a client and is not available in the community mental health center, it is necessary for the center to take responsibility for linkage. Any factors conducive to appropriate linkage are significant for continuity to take place.

Continuity of care is not to be equated with continuing service. If a client is in the hospital element of service and released needing no further treatment, it would be inappropriate or a lack of continuity to place him in outpatient care. Thus, continuity may be viewed as appropriate care and treatment in accord with the needs of the client. It may consist of moving the client to another service element or discharging him.

A problem arises when talking of the needs of the client. Who determines need; the clinician or the client? This problem is not dealt with in this study. The focus of this investigation is on selected organizational factors which are viewed as being critical dimensions of continuity. The rationale for this view concerns a practical problem that must be managed by administrators of existing
centers; namely, how to utilize appropriate mechanisms which facilitate continuity. Bass notes that it is the utilization of such mechanisms which link together the separate parts of a treatment program in a community mental health center, and administratively operationalizes continuity of care. Her notion of linkage is extended in this study to involve other agencies which provide services which do not exist in the center. This linkage is important and includes Gray's definition of continuity as involving the center accepting the responsibility for seeing that a client has completed all needed service, whether given by the center or another agency.

Viewing the mental health center as a subsystem among many other subsystems was found useful in selecting critical factors relevant to continuity. Linkage among subsystems as well as intra-linkage among service elements within the mental health system was given major consideration. The selected factors represent critical points from initial client contact with the Center until he is

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4 Rosalyn D. Bass, Continuity of Care, Historical Review, Analysis, and Definition of the Term Continuity of Care: Particularly With Respect to the Community Mental Health Center (National Institute of Mental Health, 1970).

discharged or linked with another agency that can provide the needed service. Continuity in this study represents one perspective which is viewed as being practically useful to existing centers.

When the Community Mental Health legislation of 1963 was enacted, Governor Breathitt of the Commonwealth of Kentucky designated the Kentucky Department of Health as the state agency to administer all facilities construction under Public Law 88-164, the Community Mental Health Centers Act. The Mental Health Planning Commission was established with the major responsibility for developing a long-range plan to meet the service needs of those with mental problems in the state of Kentucky. The Commission was composed of key representatives from private and professional interest groups. Their initial work consisted of three task forces appointed to study and report on major aspects of the problem. An additional staff worked on two special studies as a basis for evaluation and judgment.

The major intent of the State planning force was to develop a plan which would enable the Commonwealth of Kentucky to take maximum advantage of all public and private financial assistance available and to upgrade the mental health and mental retardation programs and services

by means of a relevant organizational pattern. Out of this comprehensive planning approach grew the idea that regional divisions be set up to provide the context for local initiative in planning and developing programs. The first step in each geographically selected region was to be the establishment of a Regional Board. This Board would be an incorporated non-profit body which would receive all grants-in-aid money from the Department of Mental Health. According to Kentucky Revised Statute KRS 203.4 to 203.500, the Board could be a non-profit corporation or a Board appointed by various county officials.

The approach used in Kentucky was that of a non-profit organization composed of interested lay citizens from the incorporated counties, backed by strong professional and governmental advisory councils. One of these non-profit corporations is currently designated as the Barren River Regional Mental Health-Mental Retardation Board. It is composed of Division A and Division B.

Division B, as set forth in the report of the Kentucky Mental Health Planning Commission, consisted of seven counties: Adair, Allen, Barren, Cumberland, Metcalfe, Monroe, and the southern portion of Hart. Recently, however, a merger which formed the Barren River Mental Health-Mental Retardation Board allowed Adair and Monroe counties to be taken over by another region. It is
Division 4B of the Barren River Board which is the focus of this study. The map in Appendix I is illustrative of the Region.

In summary, this study consists of identifying factors which are relevant to continuity of care in comprehensive community mental health centers, and to evaluate the Barren River Center in Glasgow, Kentucky on selected organizational factors found to be relevant to continuity.

Review of the Literature

The meaning of continuity of care, as it relates to mental health practices, is not a new idea. However, what does appear to be new is the conviction that mental problems are a result of numerous factors in varying degrees and ought to be treated as such. The Schwartzes,7 when assessing the theoretical implications of continuity, concluded that it rests basically on the assumption that mental illnesses are composed of diverse disabilities and that not all people with mental problems need be hospitalized. However, if hospitalization becomes necessary, the movement from the medical, social and psychological practitioners to the hospital, and back to practitioners,

must be achieved with appropriate coordination. Continuity of care is proposed in the comprehensive community mental health center concept as a solution to the previous fragmentation of services to patients encountering mental problems.

An analysis of the literature regarding continuity of care focuses around two perspectives: (1) an organizational perspective emphasizing factors that are conducive to and facilitate continuity, and (2) a clinical perspective which focuses on the recipient of mental health services.

An Organizational Perspective

With respect to the former, the Schwartzes appear to have the only publication which approaches a thorough conceptual analysis of continuity of care.\(^8\) They approach it analytically, defining and categorizing forms of continuity. Their view may be separated into four dimensions. First, there is continuity of a relationship. The Schwartzes imply that continuity exists when the same mental health practitioner sees the patient initially, conducts the evaluation, and carries the treatment through to completion. Although they point out the realistic

\(^8\)Ibid.
limitation of this dimension as being the high rate of staff turnover and the impracticality of state hospital personnel treating patients once they leave the hospital, another factor seems significant. Continuity of a relationship as defined by the Schwartzes does not take into account the chronicity of many psychiatric patients or the differential helping strategies which demand different abilities by various personnel at different points in time. This dimension of continuity would be the result of a clinical judgment according to therapeutic need. The second dimension, continuity of service, emphasizes the fact that it is not always feasible for the helper to be the same person throughout the therapeutic relationship. "Continuity of service means that help continues even though the helper may change; not the particular relationship but the type of relationship is important." Third, the Schwartzes identify a dimension called continuity of relationship with an organization. They define it in this manner:

Though the patient sees different helpers and is given a variety of treatments and services over a period of years, the organization, itself, may approach his particular needs in an integrated way. Hence, coherence and consistency make for continuity of care.\textsuperscript{9}

\textsuperscript{9}Ibid., pp. 263-65. \textsuperscript{10}Ibid., pp. 267-69.
Although this aspect of continuity would be beneficial for a client needing repeated care over long periods of time, it could also contribute to the deviant status accorded those persons with mental problems. The ex-patient may be so identified with the mental health agency in the community that he is labeled in the deviant role with the accompanying stigma. Finally, there is continuity of program. With regard to this aspect, "What is continued is not a given treatment, service or relationship, but the plan developed for the client while he was in the hospital."\textsuperscript{11} The emphasis given to this dimension is on the implementation of a set of activities clinically assessed as appropriate to needs of the client. The Schwartzes maintain that the practical realization of the various dimensions relating to continuity is possible only within appropriate organizational arrangements.\textsuperscript{12}

Another interesting and relevant study is a survey of how centers state they utilize administrative policies and practices to achieve continuity of care in their respective centers.\textsuperscript{13} Gray's results indicate that the use of various administrative techniques and practices varies greatly from item to item. The Centers in his sample

\textsuperscript{11}\textit{Ibid.}, pp. 265-67. \textsuperscript{12}\textit{Ibid.}, pp. 260-69. \textsuperscript{13}\textit{Gray, op. cit.}
indicate frequent use of some factors and relatively little use of others. For example, using the case conference as a means of facilitating continuity was mentioned by 80% of his sample while the sharing of staff was minimal. Also, most Centers assign to a single staff member the responsibility for maintaining liaison with other agencies on behalf of the client. The deficiency of Gray's survey is that the assessment is derived from what Center's say they do, and there is no criteria for determining if they actually do what they reported. Finally, an unpublished study carried out at the National Institute of Mental Health reflects some thinking on professionals in existing community mental health centers. In continuation staffing grant applications, centers are asked how they maintain continuity of care between services. The responses in a sample of 41 applications received in 1969 were coded and tabulated. Findings indicated that all the means mentioned for maintaining continuity of care, 79 percent concerned written and verbal communication among staff. Finally, the federal regulations pertaining to the Community Mental Health Centers Act view administrative factors as significant to continuity and cite specific dimensions as mandatory if a center is to qualify for matching funds. These dimensions are:
(1) that any person eligible for treatment within any one element of service will also be eligible for treatment within any other element of service;

(2) that any patient within any one element can and will be transferred without delay to any other element (provided adequate space is available) whenever such a transfer is indicated by the patients' clinical needs;

(3) that the clinical information concerning a patient which was obtained within one element be made available to those responsible for that patient's treatment within any one element;

(4) that those responsible for a patient's care within one element can, when practical and when not clinically contraindicated, continue to care for that patient within any of the other elements; and

(5) in cases where two or more of the individual elements of service are provided by different organizations, agencies, or persons, the relationships between the individual elements must be evidenced by appropriate contracts or other formal written agreements.

It is to be noted that the stipulations provided in the regulations are only concerned with the elements of service within a mental health center. This is reasonable, since
the legislation pertaining to community mental health centers, has no means of controlling other agencies. However, the importance of facilitating continuity extends not only to elements within the center's realm of services, but to all who have any bearing on the patient's life. Felix appeared to grasp this essential point; he saw in the notion of continuity of care the ingredients of free and open communication among all the individuals and agencies involved with the patient's illness. These relationships with appropriate communication linkages with other agencies would seem to be an important dimension which bears consideration in any discussion of factors that facilitate continuity in a mental health center.

Gentry, when relating the concept of continuity to the total health care delivery system, notes the need for specific coordinating mechanisms that provide linkages among and between different agencies. He proposes an inter-agency uniform unit record and record linkage system, and inter-agency case conference procedures. This idea of information sharing among different agencies for the purposes of continuity is not new to community mental health centers. One of the very raison d'etre of the centers is

to provide the initiative for coordination and integration of services. The word "Center" is to be understood not so much as a building but as a coordinated program which makes continuity of care possible.

A Clinical Perspective: Continuity as Continuance

Continuity of care has been associated with a client continuing treatment. The focus regarding this way of conceptualizing continuity has been on factors associated with the client's continuing or discontinuing service. The rationale for this view seems to be that if a client discontinues treatment when there is further need of service, there is a gap in continuity.

Continuance and the Client's Problem and Characteristics

The client's problem has been related to continuance. Blenkner's study suggests that differences in the characteristics of the problem are associated with continuance in treatment. If the problem brought to the agency is primarily a psychological or interpersonal one, there is a greater likelihood that the client will stay in casework treatment than if his problem is the need for a

concrete service. Kogan, attempting to evaluate different characteristics of clients who discontinue after the first interview, with those who planned to discontinue after the initial interview, concluded that those who do not plan their termination appear to have more complex problems. Finally, Werble's findings suggest that client discomfort is related to continuance. Ripple supports this view. Her findings indicate that those clients with greater discomfort are more likely to continue casework than those who experience little discomfort.

Continuance and the Client's Perception of His Problem

Werble, assessing client continuance with a group of adolescents, found that continuers had major problems in school and community relations, and recognized themselves as contributing to the problem. On the other hand, discontinuers had major problems in family relations and did not


19 Werble, op. cit.
recognize their involvement in the problem. This finding is in accord with Kogan,\textsuperscript{20} who found that those who failed to continue treatment placed the responsibility outside themselves. Lorr and Rubinstein\textsuperscript{21} support the findings of Werble and Kogan. In their analysis of veterans administration outpatient clinics, they concluded that those who continued treatment were more willing to express dissatisfaction with self than those who discontinued.

\textbf{Continuance and Client Attributes}

Attributes of the personality have been studied to determine if any relationship exists to continuance in treatment. The intelligence factor appears to give conflicting results. In one study,\textsuperscript{22} intelligence as measured on the Minnesota Multiphasic Personality Inventory and given to a group of outpatients in a mental health clinic indicated that those who continue treatment are likely to be more intelligent. Sullivan, Miller, and Smelser,\textsuperscript{23} in a

\begin{itemize}
\item \textsuperscript{20}Kogan, \textit{op. cit.}
\item \textsuperscript{22}Earl S. Taulbee, "Relationship Between Certain Personality Variables and Continuation in Psychotherapy," \textit{Journal of Consulting Psychology}, XXII (1958), 83-89.
\end{itemize}
similar study, does not support these findings. They found no differences in continuers and discontinuers.

The degree of disturbance and the severity of the problem have been studied with respect to continuance. Fanashel,\(^{24}\) in his study of the intakes of a family agency, reports that the state of mental health does not appear to be associated with a person continuing treatment. Lorr,\(^{25}\) assessing differences in continuers and discontinuers, found that those who continued had significantly few antisocial acts than discontinuers.

Anxiety appears to be related to continuing treatment, particularly in those studies of adult outpatient clinics. Several studies have consistently demonstrated that persons with high anxiety are more likely to continue treatment.\(^{26}\)

A patient's ability to critically look inside himself has been found to be related to continuing or discontinuing therapy. Fanashel supports the view that continuers are more insightful than discontinuers.\(^{27}\)


\(^{25}\)Lorr, op. cit.

\(^{26}\)Ibid.; Sullivan, op. cit.; and Taulbee, op. cit.

\(^{27}\)Fanashel, op. cit.
Taulbee supports this view indicating that those who continue treatment have a higher potential for self-appraisal. Finally, Gallagher reports that continuers in treatment are less defensive in reporting problems than those who discontinue.

A client's ability to persevere appears to be related to continuance. Rubinstein and Lorr found that continuers tend to be less impulsive. Levitt's findings support this view, indicating that continuers are more persistent and controlled in performing specific tasks. Finally, in support of Levitt's findings, Taulbee found that continuers are more persistent in psychological testing situations than discontinuers.

The capacity to communicate seems to influence continuance in therapy. Fanashel, studying factors

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28 Taulbee, op. cit.
32 Taulbee, op. cit.
33 Fanashel, op. cit.
associated with continuance in marital counseling, found that the capacity to communicate is associated with continuance of marital counseling. Lorr\textsuperscript{34} supports this view and points out that continuers show a greater willingness to explore personal problems. Hiler\textsuperscript{35} maintains that continuers are more verbal and consequently accounts for their greater responsiveness, while Gibby's\textsuperscript{36} findings do not support this view. His findings suggest that continuers are not necessarily more verbal than those who continue.

Finally, in regard to the patient's attributes, there is the dimension of socioeconomic background. Fanashel suggests that while there is a positive association between continuance and socioeconomic status, continuance does not seem to be associated with age, sex or race.\textsuperscript{37} Many studies of adult out-patient clinics offering psychotherapy support the idea that there is an association between continuance and socioeconomic status; they further indicate that the middle class continues in treatment more.

\textsuperscript{34}Lorr, op. cit.


\textsuperscript{37}Fanashel, op. cit.
often and longer than other strata. Coleman concurs with these findings concluding that members of the two lowest social classes are less likely to go beyond the intake phases than members of the higher classes. Another study concerned with the same problem maintains that income alone does not make the difference; the middle classes are more psychologically minded and this is the major factor.

Although there appears to be some argument regarding continuance and class as it relates to outpatient adult clinics, this is not the case in guidance centers. Lake found that "short term" contacts were prevalent among lower class families, the difference was barely significant at the five percent level. Mass and Tuckman and

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38 Gibby et al., op. cit.


Lovell, on the other hand, concluded that continuance rates were not correlated with socioeconomic status.

Continuance and the Client's Relationship with Others

The findings of Shyne support the idea that a client's relationship with significant others influences continuance in treatment. She found that when relatives of a patient were resistant, it contributed to client withdrawal. Sullivan's findings supports this view. He concludes from his findings that when the father and the mother were seen during the intake process, the probability of continuance increased. Lake, on the other hand, does not support the idea of a relationship between continuance and a relationship to significant others. He did, however, find a greater proportion of positive agreement between parents of those who continued as contrasted with those who discontinued.

Although there does not seem to be strong support for the client's relationship with the referral source


45 Lake, op. cit.; and Sullivan, op. cit.
affecting continuance, Lake and Sullivan\textsuperscript{46} found that continuers had a more positive attitude toward the referral source than discontinuers. The relationship with the caseworker would seem to be crucial in a client's continuing treatment. Shyne,\textsuperscript{47} however, points out the difficulty for the caseworker to meet the client on his own level and let him unfold the problem as he sees it.

Continuance and the Relationship Between Caregiver and Client

Up to this point, the focus has been on the client or the caregiver. Little mention has been made of the client-caregiver relationship itself; that is, the transactions that actually take place in the interview situation. This may be viewed in terms of client-caregiver attitudes and the ease with which communication take place between the client and the caregiver. Regarding attitudes, it would seem that the greater the potential for cooperation between client and caregiver, the more likely the client would continue treatment. Blenkner\textsuperscript{48} supports this view. He reports that clients who perceived the caregivers in a counseling role were more likely to continue treatment. He also notes that in the first interview, those who moved forward to accept the worker in a counseling role were more

\textsuperscript{46}Sullivan, op. cit. \textsuperscript{47}Shyne, op. cit. \textsuperscript{48}Blenkner, op. cit.
likely to continue. Kogan's findings would provide additional support to this conclusion. Lake found a greater percent of those who were in accord with the worker's notion of what the primary problem was were more likely to continue treatment. Perhaps the study by Thomas, Polansky and Kounin add insight to these findings. Both studies concerned with student perceptions of potentially helpful persons indicate that caregivers are seen as understanding, committed to help others, and view other's problem as important.

With respect to the ease with which the client-caregiver communicative efforts take place, Blenkner reported that client continuance was related to the favorableness of the client's responsiveness to the caregiver's suggestion for solving the primary problem. Those who responded favorably were more likely to discontinue treatment. Werble's findings would provide additional support to the previous conclusions. Continuers in his study showed more positive effect and behavior toward the social worker than did the discontinuers.

49 Kogan, op. cit.  50 Lake, op. cit.
52 Blenkner, op. cit.  53 Werble, op. cit.
There seems to have been more systematic research devoted to discovering why clients continue or discontinue treatment. Most of this research has not been done within existing community mental health centers. Although the factors related to continuing treatment are extremely important to the staff of these centers, the focus of this study will be on those factors that facilitate and implement continuity from an organizational perspective. This has been a recent administrative concern in existing centers.

Critical Organizational Dimensions That Facilitate Continuity

Continuity With Referral Source

A major task for community mental health centers is to provide output from the center to facilitate communication and information sharing with any agency that may have a direct or indirect bearing on the life of a client. The Regulations pertaining to the Community Mental Health Center Act realized the significance of communication and information sharing when they spelled it out as a requirement for assuring continuity.\(^5^4\) Felix\(^5^5\) also recognized


\(^{5^5}\)Felix, op. cit.
the need to achieve open communications among the individuals working with clients and among the many agencies with which people come into contact. The first point of contact involving other agencies is obviously at the point of referral. This initial point of contact where the mental health center is receiving input (the patient) from another subsystem's output is crucial insofar as the center's communication and information sharing effort is concerned. Although it would be ideal to have the same communication efforts flowing from other agencies to mental health centers, any assessment of the effort to facilitate continuity at this critical point could only be viewed in terms of a center's output. After all, a center can only control its own output, not that of another agency.

With the foregoing in mind, one dimension of facilitating continuity and increasing the potential for meaningful communication linkages with other agencies is at the initial point of contact. This is continuity with respect to the referral source. It is incumbent upon community mental health centers to provide ways to communicate back to the referral source even if it is only to communicate that the client has reached the center. This, of course, does not guarantee that continuity exists, but it does facilitate it.
Continuity with respect to the referral source, may have many implications. First, if communication is always sought with the referral source, inappropriate referrals are likely to decrease as the referral source becomes more educated to the center service capabilities and limitations. Secondly, it facilitates ongoing communication linkages between the different agencies and enhances the probability that both agencies jointly involved with a particular client will share information relevant to the client's needs. Finally, it facilitates the possibility that the care given will be relevant, not the same care another agency has already attempted, and in accord with the client's current needs.

Continuity With Referred Source

Thus far, I have considered one critical dimension in which facilitating continuity would seem to be practically significant for an ongoing community mental health program. A second dimension which bears careful consideration is that which occurs when the patient is not the input into the mental health center, but rather the output of the center going as input into another subsystem. The mandate given to community mental health centers is to follow patients until they no longer need care or help from other
agencies. In fact, Gray's\textsuperscript{56} definition of continuity involved the completion of all services seen as needed by the centers. If they are referred to other helping agencies, it is the tasks of centers to insure they get to and receive those services. Thus, the significance of communication with other agencies becomes even more pronounced when the center needs to refer a client to another agency service. Reader and Goss\textsuperscript{57} point to the fact that continuity of therapy can only be realized to the extent that communication, written or verbal, is maintained between the staff of different services. Within the mental health center services it will be recalled, the Regulations demand that "clinical information concerning a patient which was obtained within one element be made available to those responsible for that patient's treatment within any other element." Although the federal regulations pertain specifically to "within" center activity, it is important that linkage be recognized as crucial to continuing patient care when referred to another agency. Continuity with the referred source, then, is seen to be the second critical dimension at which continuity should be facilitated.

\textsuperscript{56} Gray, op. cit., p. 6.

Continuity of Follow-up

A third dimension which is seen to facilitate continuity is that of follow-up. In the final report of the Joint Commission on Mental Illness and Health, continuity of care was equated with the notion of follow-up. This aspect concerns interruptions or gaps in care which for some reason bring about discontinuance in treatment. When a client is seen as needing treatment and ongoing treatment is not being given, there is a lack of continuity. If community mental health centers are to facilitate retrieving clients who appear to be leaving center services before they are clinically assessed as ready, some mechanism must be utilized in an attempt to reach out or pull back into treatment those who appear to need continuing treatment. This seems particularly significant since numerous clients in different agency settings discontinue help before they have been deemed clinically ready. A partial factor influencing the rate of terminated patients could be due to the therapist's attempt to keep someone in treatment when he no longer need it. However, the minimal responsibility of a community mental health center is to attempt to contact those who drop out of treatment to

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58 Joint Commission on Mental Illness and Health, Action for Mental Health, op. cit.
59 Levinger, op. cit.
determine the client's reason.

Another similar dimension that is seen to facilitate continuity with respect to follow-up concerns those who are deemed clinically as needing another element of service within the center, and drop out of treatment instead of entering the new service. This problem of referrals not getting to the appropriate source has been well documented elsewhere and is not unique to community mental health centers. Some mechanism would assure contact of some form if continuity is to be facilitated. This would have to be taken into account in any assessment of whether a community mental health center facilitates continuity with respect to follow-up.

Continuity with Respect to Therapeutic Planning

The final dimension which concerns whether or not a community mental health center facilitates continuity is that of therapeutic planning. The dimensions of therapeutic planning is not specifically stated in the Regulations which operationally spell out continuity of care. However, the Schwartzes define continuity of care in terms of the

plan set for the patient. They define it as follows:

Continuity may be said to exist if the practitioner plans current help for the patient in connection with that previously given. Sometimes the patient experiences it as a continuation of previous services, but this is not a necessary criterion. In some circumstances, in order to provide for his needs of the moment, the service given must differ from past help. But if it fits into a general plan of treatment, care may be said to be characterized by continuity.\textsuperscript{61}

If patient care is to be in conformity with therapeutic need, it cannot be quick and haphazard but must result from therapeutic planning. Bass\textsuperscript{62} points to two significant aspects of therapeutic planning: (1) consistency in the long range goal and plan, and (2) relevance in accord with current needs. Both the consistency and the flexibility with regard to current needs are generally put into practice via the formal mechanisms of scheduled staff meetings which allows for verbal exchange among staff members and informal discussions among caretakers.

What is most important to facilitating continuity with respect to therapeutic planning is the existence of a plan consisting of goals and the means of achieving them. Even though a plan does not guarantee continuity, it does facilitate it and community mental health centers are concerned with this dimension.

\textsuperscript{61}Schwartz and Schwartz, \textit{op. cit.}

\textsuperscript{62}Bass, \textit{op. cit.}
In conclusion, continuity with respect to referral source, continuity with respect to the referred source, continuity with respect to therapeutic planning have been seen to be important dimension by which ongoing community mental health centers may or may not facilitate continuity of care in regard to clients.

Continuity at Intake and Staffing

Assessing whether or not a community mental health center does in fact implement continuity of care demands precise specifications as to the dimensions of continuity. At the outset, it is to be noted that continuity is not necessarily associated with continuance in treatment. After all it would be a break in continuity if a patient was moved from inpatient treatment to outpatient when his clinical needs were such that he should be terminated. Continuity in this context, is applicable not only to patients who need different types of services at different points in time, but to clients who need one service in one treatment element.

There appears to be only one study which attempts to evaluate continuity, and it only deals with patients who have undergone movement. Pugh and MacMahon, attempting

to evaluate continuity operationalized discontinuity of care, defined discontinuity as the transfer of a person from one inpatient facility to another or a readmission to a mental hospital other than that of the previous admission. They utilized this approach to the inpatients in a sample of twenty-nine public and private hospitals in Massachusetts. Continuity of care must be broadened to include all forms of care, not only inpatient.

The Schwartzes\textsuperscript{64} identify continuity of service as one form of continuity of care. As was previously discussed, continuity of service implies that because of the comprehensive treatment programs that a center makes possible, it becomes possible for a client's service to continue parallel to the patient's progress although caretakers may change along the way. As long as the movement is in accord with therapeutic need and it in fact is carried out, then continuity of care is said to have been implemented.

What comprises the implementation of continuity of care at intake then, is whether or not a client is rendered clinically assessed services which are appropriate to his needs. The assumption is that the judgment made by professional staff is in fact accurate. Although this may be

\textsuperscript{64}Schwartz and Schwartz, \textit{op. cit.}
questioned, there are measures to increase the reliability of the judgment made. First, when a client comes to the mental health center, the intake and screening process allows a variety of professionals with different orientations to generate a plan for the client. When consensus is reached regarding the type and element of service, many views have been taken into account. This increases the possibility that the selected course of treatment is in accord with therapeutic need. If it is implemented, continuity is more likely to have been implemented. Secondly, an added measure of reliability occurs approximately ninety days after the course of treatment has begun. A utilization review committee determines if the course of treatment was appropriate and in conformity with therapeutic need.

Continuity of Movement

It has been noted that clinical recommendations are made at screening and evaluation; if they are carried out, continuity has occurred. However, after the patient has been processed and placed in the appropriate element of service, discontinuity may occur if it is determined that the client needs another element of care and does not receive it. The Regulations specifically spell out "that any patient within any one element of service can and will be transferred without delay to any other element whenever such a transfer is indicated by the patient's clinical
needs." Movement to another element must be made in conformity to therapeutic need if continuity is to be implemented. Celebreeze saw this as the essential ingredient of continuity. He notes that the key to continuity is in the ability of the patient to move from one element or treatment service of the center to another according to his therapeutic needs. On the other hand, if a client does not need to be moved to another element of care and consequently stays in the same element in accord with therapeutic need, continuity is said to exist. Thus, continuity with respect to movement has two dimensions: (1) those clients that move from one treatment element to another, and (2) those that stay in the same element in accord with therapeutic need.

In summary, crucial clinical recommendations may be made at two separate phases of the program. The first is at intake and screening where the decision is made regarding the appropriate element of care; and the second is during the time of treatment itself. Clinical recommendations in accord with therapeutic need must be implemented if continuity is to be assured.

Purpose and Relationship to Social Work Practice

At a recent symposium of the National Association of Social Work, Bertrand Black declared "that if there is one concept in health services for which social workers have stood solidly, it is continuity of care." He continues with social workers' interest in continuity in asking, "who better than social workers should appreciate the consequences of lack of continuity?" However, it is significant to note that Black concludes his discussion of continuity by pointing to the evidence that social work has done little to contribute to the knowledge of continuity of care.

In the area of community mental health, social workers are increasingly called upon to fill administrative roles. A large number in fact are becoming center directors of agencies. Thus, the primary purpose of this study as it relates to social work practice is to provide practitioners working in community mental health centers with a practical and operational way of assessing continuity.


67 Ibid., p. 132.

68 Ibid.
The concern for clients who become involved with the health care system is not a recent occurrence in social work. As early as 1905, Cabot identified the role of social work as assisting with psychosocial factors that interfere with a client's medical care. The historical link of social work to a hospital setting perhaps accounts for the few studies which view social work in the health care system outside the hospital in the community. This is not to imply a decline in hospital social services. In fact, a recent article indicates that hospital social service expenditures point to the increased concern about the significance of social work in achieving a comprehensive care system accessible to all, and that achieving this means needed radical reform and some other focal point than the hospital. Wertz suggests that the role which has been defined for social work must be redefined by social work itself, and others maintain that social work must

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71 Teague, op. cit., p. 66.

become more flexible in adapting knowledge if it is to meet health needs.\textsuperscript{73}

In the area of mental health in particular, social work historically has been concerned with the quality of care rendered to those encountering mental problems. As early as 1840, the social action efforts of Dorothea Dix brought to public view the lack of quality services being rendered to the mentally ill.\textsuperscript{74} Her efforts culminated in the establishment of additional mental hospitals and improvement in hospital care. However, after public interest declined and hospitals increased in size and became more isolated from the community, a need and recognition of the importance of community ensued. By 1905, social workers were becoming identified with community psychiatric clinics, and initially were employed "to give direct service to patients in neurological clinics in New York City and at the Massachusetts General Hospital in Boston. In 1906, the State Charities Aid Association of New York first employed a social worker whom they called an aftercare agent, and assigned her to two mental hospitals to facilitate release of patients and assist them in their


community adjustment. 75

The recognition of the detrimental effects of prolonged hospitalization was more pronounced by 1939. Myerson, 76 for example, labeled the damaging effects of lengthy hospitalization as a "prison stupor." Subsequent studies 77 have provided more evidence to substantiate Myerson's conclusions. Such studies are increasingly calling attention to the negative consequences of labeling and some of the difficulties in de-labeling.

The field of social work has not lost its concern for mental health. Speaking of community mental health practices, Brotman and Livenstein, 78 suggest the role model of organizer-educator for the social worker. Within this model, they maintain that the primary objective of the


practitioner is to mobilize and help integrate the thoughts and actions of the diverse professionals toward stated goals of change in the care delivery system. As new objectives are defined, the staff roles will require changing, and staff methods may then be adjusted to fit the goals and targets chosen for intervention. Flomenhaft, on the other hand, sees social works' role, as primarily a clinical one.

The role of the social worker in this context is seen to be a clinical one with his skill and experience in therapy providing the confidence that he can manage a variety of seriously ill patients and families. The basic ingredients of this clinical approach are viewed in accord with traditional social work services since casework has always viewed the family, interaction, role functioning, and home visits as extremely important.

Social workers have also been concerned with follow-up and what makes it successful. There have been attempts to determine who will make successful adjustments to community life, who will be poor risks and the factors

80 Ibid.
that appear to be associated with success. Ullmann and Berkman\textsuperscript{81} found that marital status, education, diagnoses, and the presence of living relatives are not significant factors in predicting community placement success or failure. In another study, they found that the number of hospitalizations (two or fewer), length of hospitalizations, and type of ward are indexes of good prognoses.\textsuperscript{82} Cunningham,\textsuperscript{83} in a similar study, found successful placement of released mental patients to be associated with youth, unmarried status, long hospitalization, and meaningful involvement in such activities as employment and vocational training. It is important to note the possibility that some extraneous factor could have caused these variables to vary together. Tanaka\textsuperscript{84} found the greater the involvement, the less the rehospitalization. In their


program only a small percentage were rehospitalized one year after termination from the program.

Organizational linkages have been viewed as significant. Collaborative efforts among different helping agencies have been stressed by existing programs. Scoles and Fine, in their description of the West Philadelphia Community Mental Health Consortium, stress the significance for the community, state mental hospitals, and a community mental health center to collaborate in providing an environmental structure conducive to the continued well-being of chronic mental patients. They emphasize the necessity of a therapeutic milieu both in the hospital and in the community surroundings, with appropriate collaboration between the different agencies involved in the caregiving function. From their viewpoint the only way chronic mental patients can be rehabilitated and involve themselves meaningfully in community life is by first reidentifying with the community. This can only be done by initially focusing on the patient's domestic milieu with the integrated efforts of the community, the patient, and the mental health center bringing to bear its part in a therapeutic community process. The structural arrangements with

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which the patient comes in contact, including all community agencies, is the foundation on which to build activities. Mass\textsuperscript{86} supports this view and extends its importance to structural linkages among different organizations. He notes that interorganizational linkage patterns among social welfare agencies may materially affect the quality of service to clients. The effect of lack of coordination among different agencies and clients has been noted in the area of mental health\textsuperscript{88} and delinquency.\textsuperscript{89} Pierre\textsuperscript{90} agrees with Scoles and Fine but adds the importance of collaboration and communication among different professional disciplines as being crucial to meeting the total rehabilitation needs of clients.

With respect to organizational arrangements within and between agency structures that facilitate better client care, the Massachusetts General Hospital set up what they

\textsuperscript{86}Ibid., p. 80.


\textsuperscript{89}Walter B. Miller, "Inter-Institutional Conflict as a Major Impediment to Delinquency Prevention," Human Organization, Vol. 17, No. 3 (Fall, 1958), pp. 20-30.

\textsuperscript{90}St. Pierre, \textit{op. cit.}, p. 105.
termed a Transfer Office. Their concern about the inadequacy of the placements to nursing homes led them to set up this office to develop and deliver more efficient and appropriate post-hospital care to elderly, chronically ill patients. Although this office was not set up specifically for mental patients, the goals of this transfer office have significance to the notion of organizational arrangements being conducive to patient care. They are to (1) test the proposition that closer cooperation between nursing homes and a general teaching hospital will improve the care of patients, (2) learn the most effective methods of communication and affiliation between nursing homes and general hospitals that will contribute to continuous and comprehensive care of patients, (3) develop methods of consultation and educational exchanges, (4) participate in any community action and education appropriate to bring about improved care of patients. What is important is the arrangements that appear to facilitate better care for clients. They are (1) meaningful communication linkages between agencies working with a client, (2) educational exchanges, and (3) participation and involvement with other agencies structures in the community that appear to be

influential in facilitating patient care. Hall, Smith and Bradley, in evaluating the delivery of mental health services to the poor in urban areas, found that two-thirds of the population studied needed some type of external help and support if they were to be helped. He concluded that neighborhood based referral networks and mental health networks with appropriate linkages must be strengthened if care is to be rendered appropriately. Neugoboren, dealing with social service delivery, agrees with Hall, Bradley and Smith in stressing the importance of the structure of the delivery systems. He maintains that we must be concerned with the organizational and staffing arrangements that will facilitate and expedite service. Gallagher provides an illustration of how a central intake was set up for social services to avoid patient shopping for specific services in different places, and Barnard describes the


Human Resources Center of Denver whose primary objectives are to serve as a clearinghouse for information and referral, document evidence of unmet need, and to act as a coordinating function in the health field. Both Gallagher and Barnard support the need for more effective organizational linkages to enhance continuity.

An important dimension with respect to social work's concern for appropriate care being rendered to clients, is that of client feedback regarding service. It appears that little research has been done in this area and Piven\(^96\) suggests that the structure and delivery of services makes one question whether client need is really the basis of service. Although Teague\(^97\) points out the emerging power of the health consumer scanty evidence exists of any real power of mental health consumers. However, in one aftercare and rehabilitation program in Philadelphia, a serious attempt is made to allow patients to negotiate their services.\(^98\) They elect their own representatives to a self-government council and handle most activities and decision making except that which requires explicit professional expertise. The very terminology of consumer has


\(^{97}\)Teague, op. cit., p. 66.

\(^{98}\)Scoles and Fine, op. cit., p. 78.
been viewed as crucial to patient care. From this stance, care is not dispensed from the professional to the client, but negotiated. This is seen to lead to a greater demand for competence and service stemming from the consumer.99

If the client is not taken into consideration, the results can be devastating. Ginsberg100 points out that there is little in the social welfare literature on the issue of civil rights and mental illness, yet research indicates that involuntary commitment to mental hospitals happens mostly to the poor. Social work being a social welfare profession must take steps to reform this inequity. Black,101 too, strongly advocates consumer organization if we are to have the "community" that is implied in community mental health. Finally, it has been suggested that not only consumer organization and participation are significant with respect to the client, but of equal importance is consumer evaluation.102 There must be feedback from the


consumer if any meaningful evaluation is to take place.

A search of the social work literature bears out Black's criticism that minimal specific work has been done with regard to continuity of care. However, it is apparent that social work practitioners are concerned about "organizational facilitators" that enhance the possibility of continuity. What appears to be lacking is the specification of dimensions that enable the practitioners to find operational ways of determining if he is achieving the care that he sets out to achieve.

Currently, social workers are increasingly being called upon in community mental health centers to fill administrative roles. One major objective in this program is continuity of care. The dimensions relating to continuity must be specified and operationalized if those administrators are to evaluate their programs and contribute to the betterment of the communities they serve.

The Nature of Program Evaluation

Evaluation of existing mental health programs has recently come to the forefront. This new trend can be linked to a more educated public with more awareness and involvement in public policy decisions. The trend toward increasing accountability of programs is only beginning;
the need as well as the demand will be greater. Supple-
menting this demand are those who handle the finances.
The worth of programs must be proven or money will not be
given. This is the reality that confronts many existing
programs.

However, the worth of programs may be determined by
various factors; seldom by analyzing an objective set of
indices that give an absolute measure of value of a pro-
gram's worth. Still, Caplan would argue that evaluation
studies should be increased, and although it may be expen-
sive, refining and continuing the evaluative process is the
only way to improve programs. It is not only that programs
must prove their worth, but "only built-in self evaluation"
can provide the self-correcting checks by which progress is
made. It is within this framework that continuity of
care will be assessed. The selected dimensions hopefully
will be a start for existing programs to look at critical

103 Edward A. Suchman, Evaluative Research (New

104 Martin B. Loeb, "Evaluation as Accountability," in Leigh M. Roberts, Norman S. Greenfield, and Milton H.
Miller, Comprehensive Mental Health (Madison: The Univer-

105 Gerald Caplan, "The Nature and Problems of
Evaluation in Community Mental Health," in Leigh M.
Roberts, Norman S. Greenfield, and Milton H. Miller, Com-
prehensive Mental Health (Madison: The University of
dimensions related to continuity and utilize them in a manageable way.

The complex and difficult task of determining which dimensions of continuity to be used and how to utilize them is not unique in the evaluation of programs. Bloom has noted that to achieve success in program evaluation in mental health is virtually impossible. Although considerable difficulty existed in deciding the dimensions of continuity to be utilized in this study, choosing the perspective of critical dimensions as clients pass through the system makes the task manageable and increases the potential for future use. Too often, the goal and the means of obtaining the goal is vague and elusive. In this investigation, the means will be quantified in order to give a percentage of continuity.

Many of the assumptions regarding continuity are open to question. For example, there is implicit in the notion of continuity that if it is achieved, then improved social functioning will result. There exists considerable discrepancy regarding what constitutes continuity and at present there is no evidence to support a relationship between any dimensions related to continuity and client

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improvement. This difficulty is not unique to this study, but is encountered in virtually all evaluations of social programs. Suchman\textsuperscript{107} notes that oftentimes a large proportion of the program goals rest on questionable assumptions derived from common sense and not proven effectiveness. Likewise, continuity of care and the various dimensions seen as being critical in this study have been largely derived from what practitioners reported to be crucial in the report of the Joint Commission on Mental Health and Illness. More specific studies about whether the dimensions of continuity are actually implemented and whether they contribute to client improvement is going to be the ultimate test of program success.

The methodological difficulties complicate the matter further. Standards and measurement devices which determine how "appropriate" an activity is, is subjective and many times arbitrary. For example, it is assumed that communicating back to the referral source will facilitate communication and be conducive to continuity for the client. Actually, if this activity was carried out as an end in itself, it would soon lose its usefulness for continuity. Although approaching continuity with the referral source in a quantitative way is indicative of communication

\textsuperscript{107}Suchman, \textit{op. cit.}, p. 38.
between agencies regarding a patient, it could in fact be a routine which says nothing about the quality of communication.

Continuity of care, being a program goal in community mental health programs implies values regarding its usefulness among mental health practitioners. The concept of values is extremely important to program evaluation. Although value considerations are inherent in any activity, they are particularly crucial in evaluative research. Value positions need to be spelled out in detail. According to Greenberg, in the process of evaluative research, the administrative structure should be forced to specify those values sought or else evaluation cannot take place. At the Barren River Center the value given continuity of care is spelled out in general terms including all of the dimensions previously discussed. There is a lack of specificity about how this program goal is to be measured and evaluated. Part of the purpose of this study is to provide explicit ways of viewing whether activities related to continuity are being carried out. Suchman has warned that unless the activities are explicated in specific terms, and be related to a given goal or goals, it cannot

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109 Suchman, op. cit., p. 38.
be the subject of evaluation research.

Although many subjective judgments are being made in this study about measuring continuity, it in no way negates what is traditionally viewed as the scientific method. Suchman\textsuperscript{110} maintains that scientific method is not bound by subject matter or objective. Thus, evaluative research, having no particular methodology of its own, attempts to approximate the scientific mode of inquiry as closely as possible. The research methodology is similar to any other research design in that it utilizes techniques that facilitate scientific inquiry. Essentially, the basic difference in evaluative research is in the purpose for which it is carried out, not necessarily in the design. Although, Suchman\textsuperscript{111} would emphasize many of the practical problems associated with evaluative research, he also agrees with Klineberg\textsuperscript{112} that evaluative research should be conducted as vigorously as possible in accord with the scientific method. It is in this context that this study was generated and completed.

Different types of research, all being conducted according to different purposes but within the scientific

framework, has been viewed by several authors. Zetterberg\textsuperscript{113} calls attention to descriptive studies and those attempting to provide explanations. In descriptive studies, the focus is on diagnostic processes in order to develop taxonomies. In explanatory studies, the approach is on testing hypothesis to explain the relationship between different phenomena. In similar vein, Hovland\textsuperscript{114} has distinguished between "program" and "variable" testing in evaluative research. Testing variables refers to specifying components of a program and measuring their effectiveness. Evaluation of programs, on the other hand, deals with the practical objective of whether or not exposure to a given program is accompanied by specific desirable effects. A major limitation in program evaluation, according to this distinction is the lack of external validity or generalization. This, of course, is one of the major limitations in this study. Finally, Hyman\textsuperscript{115} differentiates research activity into the diagnostic study, the


theoretical or experimental, and the evaluative or programatic. In the diagnostic study, the exploration of a problem area is undertaken whereas in the experimental variables are controlled to determine if that part of a program is actually getting the effects it purports to get.

Caplan\(^{116}\) organizes the evaluative process in community mental health around three types of studies: (1) evaluation of process, (2) evaluation of achievement, and (3) administrative evaluation. In evaluation of process key questions that need to be answered concern the elements of a given program and what actually takes place. The major task is a descriptive account of what has taken place in precise terminology so that the similarities and differences between different programs staffed by different workers, or by the same workers involved with different client populations or the same population at different times, may be compared. The major objective in process evaluation is to describe, classify, and define in order that replication is possible.

Complications that arise in process evaluation should be noted. A mental health program is more than an input into a community or client from a given worker or clinic group. It is a complex, reverberating interchange

\(^{116}\)Caplan, op. cit., p. 4.
which effects and is affected by the other in a series of feedback operations. Thus, it becomes more difficult to describe, classify, and define. Another problem arises due to the nature of the type of worker generally involved. As Caplan points out, the person engaged in community mental health practice who is himself an important factor in determining the detailed nature of the method or technique, usually does not have the talent nor the interest in this type of endeavor. Consequently, a research person must be hired and for effective evaluation of process, there must ensue relatively tension-free collaborative relationships between practitioners and researchers.\textsuperscript{117} This, too, can have its problems.

Evaluation of Achievement is primarily interested in the degree to which goals were attained with the methods employed. Ideally, specification of goals which permit measurement are developed ahead of time, and then change can be accounted for. The problem is demonstrating whether the change was in fact a consequence of the program. In evaluation of achievement, there needs to be comparison groups not exposed to programs, and not only specifications of goals but also specification of the means adopted to achieve the goals.\textsuperscript{118} From Caplan's stance, part of this

\textsuperscript{117}Ibid., p. 4. \textsuperscript{118}Ibid., p. 6.
investigation is of the nature of evaluation of achievement. The goal of continuity of care is being evaluated to determine to what extent it exists. A major problem in this evaluation is not only vagueness associated with the goal but also lack of specificity regarding the specific activities that achieve the goal. The activities that are spelled out as achieving continuity of care have never been empirically related to client improvement. Thus, in order to carry out evaluation of achievement as Caplan views it, the program being studied would have to implement those variables being spelled out as related to continuity, and later compare another program who do not make use of the activities seen to facilitate continuity. Needless to say, in an evaluation of that type, it would be extremely difficult separating other factors influencing the program effects.

There are many problems involved in achievement evaluation in community mental health. Problems of definition regarding what constitutes mental disorders have little inter-observer reliability, and agreement on valid methods to measure change is difficult to obtain. Another problem consists of measuring long range goals in a short period of time. Assumptions must be made regarding the relevance of short term goals and their necessity as a step
toward long-range ones. Focusing on intermediate goals increases limitations in the evaluation but is necessary for an evaluation to be done realistically. The third potential problem in achievement evaluation concerns the methodology itself producing the observed results. This can be minimized by comparison and control groups. Finally, there is potential problems in the relationships between researchers and practitioners. Whereas in process evaluation there is likely to be less tension because of the closeness of the working relationship and the fact that it is primarily a descriptive study, in achievement evaluation the research process is likely to be by one perceived as an "outsider" who is assessing the worth of the methods of the practitioner.\textsuperscript{119} Fortunately, this was not a problem in this study due to previous relationships with the staff members.

In administrative evaluation, Caplan notes that a major emphasis is on monitoring the system to insure quality control. One of the practical aspects of specifying the dimensions related to continuity in a quantitative manner, is to enable administrators to manage the system and insure that necessary activities relevant to a given goal are in fact carried out. In this study, this practical

\textsuperscript{119}Caplan, op. cit., p. 6.
aspect is considered extremely important to the profession of social work which emphasizes utilization of knowledge.

Amidst the complexities associated with evaluative research, the goal for this study is within the category the National Institute of Mental Health calls an assessment of practice study, and which Suchman labels an effort evaluation. In this type of evaluation, there is the assumption that the specified activities are valid means of reaching the higher goal. The dimensions of continuity are implicitly seen to contribute to improved client functioning. What will ultimately have to be done is to develop a study to determine if continuity as specified in this study is correlated with client improvement.

In conclusion, Suchman has stated that "the most identifying feature of evaluative research is the presence of some goal whose measure of attainment constitutes the main focus of the research problem." In this study, selected dimensions viewed as critical to continuity are being specified in a measurable way, and the Barren River Center will be evaluated with respect to these dimensions.

\(^{120}\) National Institute of Mental Health, "Guidelines for the States," 1969, p. 4.

\(^{121}\) Suchman, op. cit., p. 37.
CHAPTER II

METHODOLOGY
Setting

The study will be conducted in a community mental health center in south central Kentucky. This "catchment area," considered Region IV in the state plan, has a population of 185,727. Previously Region IV operated as two separate and distinct mental health regions. Currently, subregion 4B of Region IV is composed of Allen, Barren, Hart, Metcalfe, and Monroe counties, with a population of approximately 95,000. It is this area that is the subject of this investigation.

In this rural region, the largest town is Glasgow, with a 1970 population of 11,301. Prior to 1969, when a systematic method of statistical reporting was developed by the Comprehensive Care Centers, no substantiated data on the extent of mental illness was available except information concerning admissions to state hospitals from the area. A 1967 staffing grant application shows that there were 297 mental hospital admissions from subregion 4B in that year.

The mental health center is located in Glasgow in a recently constructed medical plaza. It is in walking distance from the T. J. Samson hospital which has a newly
constructed psychiatric wing with twenty-two beds allocated for inpatient psychiatric facilities. This section of the hospital has complete psychiatric facilities, including rooms and equipment for recreation and occupational therapy and treatment services. The staff of the services consists of psychiatrists, social workers, mental retardation specialists, alcoholism specialist, clinical psychologists, and psychiatric nurses.

**Operational Definitions**

The following definition has been formulated from the dimensions of continuity, and will be utilized for the purposes of this study. In a community mental health center, continuity of care is planned care which facilitates and carries out continuing treatment when clinically assessed as appropriate. Operationally it exists to the extent that: (1) administrative mechanisms facilitate communication linkages with other agencies, (2) administrative mechanisms facilitate the retrieval of patients who drop out of treatment, (3) administrative mechanisms facilitate therapeutic planning, and (4) clinical recommendations in accord with clinically assessed need are implemented.
Continuity with Respect to Referral Source

When a potential client is referred to the mental health center, it is crucial for the center to communicate clinical information regarding the mental health needs of the client back to the referral source. This is particularly significant if the agency referring continues to have contact with the person referred. However, there are times when a clinical decision may be made not to share information regarding the client. For example, the client may insist that any information learned remain completely confidential between himself and the center. In any event, it is the philosophy of community mental health advocates and practitioners that it is the responsibility of a center to maintain ongoing contact with the referral agency about all potential clients referred for mental health services. This responsibility for maintaining contact is seen to facilitate ongoing communication with referring sources and to decrease the possibility for the potential client to get "lost" between agencies. Minimally then, any contact by the Mental Health Center with the referring agency once the potential client is seen at the center is indicative of the center facilitating communication with the referral source. This communication may simply be a notice relating to the referring agency that the client has contacted the center. However minimal the communication regarding the client, it
is indicative of the mental health center's attempt to provide linkage between agencies and minimize the potential for discontinuity. Communicating back to the referral source is even more important if the potential client does not need the services provided by the center.

Whatever the information communicated back to the referral source, it is important that it be contained in the case record. Written records are considered extremely important in community mental health centers in order that all information relating to the client be stored for potential future use. If a therapist sends information or communicates in any way, it is to be contained in the case record. Consequently, the method for assessing whether or not the Barren River Center facilitates communication and minimizes the potential for discontinuity with the referral source, is to examine the case record to determine which information is sent to the referral source. This information must be at least as minimal as letting the referring agency know that the client has contacted the center. Any other information involves matters of clinical judgment and is of no interest in this study.

Thus, the first variable concerns continuity with respect to the referral source and may be assessed as follows:
V 1 Continuity With Respect to the Referral Source

This variable can be assessed quantitatively by counting the number of cases in which minimal communication regarding the potential client is given to the referral source. Minimal communication is at least contacting the referral source and advising them whether or not the potential client has made contact with the center. A percent continuity may be obtained as follows:

\[
\text{Number of Cases Facilitating Continuity With Respect to the Referral Source} \times 100
\]
\[
\begin{array}{c}
\text{Number of Cases} \\
\end{array}
\]

Continuity with Respect to the Referred Source

Similarly to the referral source, community mental health centers have the responsibility of providing linkages with other agencies to which they refer clients. They not only have the responsibility of referring clients to other agencies but to insure that the contact was actually made. This communication with the referred agency is seen as minimizing potential discontinuity resulting from lack of linkages between agencies. Thus, a minimal requirement for facilitating continuity with respect to the referred agency is to provide follow-up of each client referred to other agencies to see if he actually got to that service. This is also important for the storage of information about the client for future use, and is contained in the case record.
Consequently, the method for determining whether or not continuity is facilitated with respect to the referred source is to use the case record to determine the extent in which a client was referred and whether or not there was follow-up to determine if the client actually got to the referred agency. This may be viewed as follows:

V 2 Continuity with Respect to the Referred Agency

Quantitively, this is the number of cases which have been referred to another agency outside the center and followed up with the other agency to determine if they actually made contact over the number of cases referred. It may be expressed as percent continuity in the following way:

Number of Cases Facilitating Continuity with Respect to the Referred Agency

\[ \frac{\text{Number of Cases Facilitating Continuity with Respect to the Referred Agency}}{\text{Number of Referred Cases}} \times 100 \]

Continuity with Respect to Follow-up

The third dimension which was seen to facilitate continuity concerns the client directly. This aspect regards attempted communication with those who discontinue coming to the center for service, when they are clinically assessed as needing further treatment. It will be called continuity with respect to follow-up.
V 3 Continuity with Respect to Follow-up

This measure of output may be assessed quantitatively by counting the number of attempts (one per case record), whether in writing, via phone, or home visit, to contact a patient who dropped out of treatment, over the number of case record. It may be expressed as follows:

\[
\frac{\text{Number of Attempted Contacts to Retrieve Clients}}{\text{Number of Cases}} \times 100
\]

A fourth dimension of continuity is that of therapeutic planning. Planning is essential if gaps in service are to be minimized and if there is to be the sharing of information spelled out in the Regulations. Not only the treatment plan is significant for facilitating continuity, but also the ongoing plan which may change in accord with therapeutic need. A treatment plan and an ongoing plan must exist in the case record if record sharing is to be facilitated. The Regulations in fact stipulated that information in one element be made available to those in any other element. Thus, the variable of continuity with respect to therapeutic planning is another indicator of the extent to which a center facilitates continuity of care. However, it consists of two subvariables as follows:
V 4  **Continuity with Respect to Treatment Plan**

This can be quantitatively assessed by counting the number of treatment plans in the total case records and viewed over the total number of cases. This may be expressed as follows with the results being the percent continuity on this dimension:

\[
\text{Number of Treatment Plans in Case Record} \times 100
\]

\[
\text{(one per record)} \quad \text{Number of Cases}
\]

V 4b **Continuity with Respect to the Treatment Summary**

This can be found quantitatively by counting (one per case) the number of cases where there is a summarized version of the plan and why it was or was not attained over the number of cases. It may be expressed as percent continuity as follows:

\[
\text{Number of Appropriate Treatment Summaries} \times 100
\]

\[
\text{(one per record)} \quad \text{Number of Cases}
\]

The next two variables involve what is considered the actual implementation of continuity of care. As was previously discussed, the emphasis for the first variable is on staffing continuity. If a clinical recommendation is made in accord with therapeutic need, continuity has occurred if it is carried out. The first aspect of implemented continuity is the intake and staffing recommendation that a patient be placed in the appropriate treatment element. Thus, intake and staffing continuity is the fifth variable.
V 5 Intake and Staffing Continuity

The percent continuity with respect to this dimension can be quantitatively expressed by counting the number of recommendations to a specific element of service as compared to the number of times the patient actually began service in the new element. It may be illustrated as:

\[
\frac{\text{Number of Recommendations Carried Out}}{\text{Number of Clinical Recommendations at Intake and Staffing}} \times 100
\]

Finally, there are clinical recommendations regarding patient movement to another element once he has reached his designated element and received the necessary treatment. For example, a client may be placed on outpatient status, become worse and need hospitalization. If continuity is to occur, movement to the appropriate element must take place. Thus, the sixth indicator that represents recommendations in accord with therapeutic need after the patient has been placed in an element of service will be called continuity of movement.

V 6 Continuity of Movement

As used here, continuity of movement which will be concerned with ongoing evaluation and evidenced in the progress notes of the case record, will be determined by counting the number of clinical recommendations relating to movement from one element of service to another in conformity with therapeutic need in contrast to the number of recommendations carried out. It is expressed as follows:
The foregoing six variables, will provide indicators of the extent to which continuity is being facilitated and achieved at the Barren River Center. Since the client's case record is the major repository for written communication among staff, it is the case record which will provide the information relevant for this part of the study.

The sample of 200 was randomly selected from a total of 989 clients who have been terminated from the center's services from January 1, 1968 until January 1, 1972.

Since this study was not concerned with the type of client that came to the mental health center but with the efforts of practitioners to facilitate and implement dimensions related to continuity, there was no attempt to categorize the client characteristics or particular diagnoses. However, an extremely noticeable characteristic of the samples being studied was that they were largely from the lower socioeconomic class. This of course may have considerable influence on the way practitioners carry out the functions related to facilitating continuity.
Limitations

Since this is a case study, and one in which no specific hypotheses is being tested, no generalization can be made. Also, because of the different structural arrangements due to different geographic location as well as different ideological orientations, the findings in this study are not necessarily indicative of other community mental health centers. This study can be viewed as practically relevant only to the Barren River Center. However, the dimensions in this study may suggest fruitful ways in which other centers may evaluate continuity for practical purposes.

Ideally, with this type of goal oriented evaluation, a comparative analysis of numerous programs would yield comparative results in terms of the degree of goal achievement. However, this would require more time than is possible with this project.

Using written records to determine whether or not an activity was carried out, may not actually be a valid indicator. However, there is an emphasis placed on the value of records as they relate to community mental health centers. They are not viewed as simply providing accountability, but as an important dimension in providing appropriate care and keeping ongoing information about a
potential client to be served. This is seen to prevent duplication of effort and relate past care with current treatment of a person in his own community.

The dimensions regarding continuity that are utilized in this study represent only minimal requirement for continuity to exist. This was done for quantification purposes. Actually continuity involves other dimensions which involve clinical judgments and could be the basis for another study.

Finally, the evaluation of continuity as viewed by the client receiving service is not in this study. It may be that the dimensions used in this study to determine whether continuity of care exists have no relationship to the client's view of his treatment or to treatment outcome.
CHAPTER III

FINDINGS AND ANALYSIS OF FINDINGS
Findings

In answer to the question, "to what extent does the Glasgow Barren River Comprehensive Care Center facilitate and achieve continuity of care," the findings will be presented in the order that the variables were discussed. The tabulated data is shown in Table I.

Continuity with Respect to the Referral Source

Continuity with respect to the referral source was measured in terms of the mental health centers' communication with the agency referring the prospective client. Any type of communication was sufficient, as long as it was indicated in the case record. Of 142 cases where communicating back to the referral source would have been applicable, there were only 48 instances of communication of any kind. This means that continuity, as measured by facilitating communication with the referral source seems to have occurred one-third of the time. However, it is to be noted that when information concerning the prospective client was requested by the referral source, it was sent in every case. It appears that on this dimension the mental
| Continuity with Referral Source | No. of Cases | 142 | No. of cases in which Communication is Facilitated | 48 | Percent of Continuity | 33.8 |
| Continuity of Follow-up | No. of cases of Facilitating Communication | 24 | 18.1 |
| Continuity with Referred Source | No. of cases in which Communication is Facilitated | 9 | 81.8 |
| Therapeutic Planning (a) | No. of Treatment Plans in Record | 182 | 98.4 |
| Therapeutic Planning (b) | No. of Termination Summaries Evaluation Plan | 160 | 86.8 |
| Continuity of Intake and Staffing | No. of Recommendations Implemented | 197 | 98.5 |
| Continuity of Movement | No. of Recommendations Implemented | 54 | 83.0 |
health center under study views itself as communicating with the referral source only when specific information is requested. Table 2 illustrates the results related to this dimension.

An additional 43 cases, or 24.5 percent of the total cases were not applicable. These were self or family referrals.

Finally, as is noted in Table 3, when the source of referral is placed in separate categories, the private physician appears to be the major referral source to the center. Self-referrals are second in number, while the total of other agency categories including public assistance, child welfare, the courts, and the T.B. Hospital refer the least.

Continuity with Respect to the Referred Service

The second indicator of facilitating continuity, that of continuity with the referred source, was measured by the extent of the center's communication with another agency when the client was seen as needing the services of that agency. Again the type of communication was viewed as incidental. Even though the method of referral has been said to be directly related to the nature of the problem
TABLE 2

PERCENT CONTINUITY WITH RESPECT TO THE REFERRAL SOURCE OF THOSE WHO REQUESTED INFORMATION

<table>
<thead>
<tr>
<th>Continuity with Referral Source</th>
<th>No. of Cases</th>
<th>No. of Cases Information Requested</th>
<th>No. of Cases Information Given</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39</td>
<td>39</td>
<td>39</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE 3

THE SOURCE AND PERCENTAGE OF CASES REFERRED TO THE MENTAL HEALTH CENTER

<table>
<thead>
<tr>
<th>Source</th>
<th>No. of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>71</td>
<td>35.5</td>
</tr>
<tr>
<td>Self</td>
<td>58</td>
<td>29.0</td>
</tr>
<tr>
<td>State Hospital</td>
<td>33</td>
<td>16.5</td>
</tr>
<tr>
<td>Public Assistance</td>
<td>14</td>
<td>7.0</td>
</tr>
<tr>
<td>School</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td>Court</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td>Attorney</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>T.B. Hospital</td>
<td>1</td>
<td>0.5</td>
</tr>
</tbody>
</table>
and that all referrals should be confirmed in writing, the only requirement for the center to score a yes on continuity with referred source, was any communication regarding the client. This of course had to be recorded in the case record.

The findings on this dimension indicated that after a client completes the services prescribed for him at the center, he is seldom referred to another helping agency in the community or another source of help outside the community. When he is referred, it is usually left up to the client to make contact and the information concerning the client is sent when requested. Although there appears to be a high percent continuity with respect to the referred source, the extremely low number of cases referred to other agencies needs to be emphasized so this can be seen in total perspective. Perhaps an analysis of the low referral to other agencies would indicate that although continuity appears to be high on this dimension, it still does not exist. It must also be remembered that the community mental health center in question, offering many different services with many different professionals, might provide such good care that referral is not necessary. From this

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vantage point, the high percent continuity on this dimension would indicate that appropriate care is so good that facilitating this dimension is seldom needed.

Continuity of Follow-up

The third indicator, that of continuity regarding follow-up of clients who terminate from treatment without notifying their therapist or someone on the center staff, was measured to the extent that the therapists attempted to retrieve or find out their reason for termination. The method of follow-up made no difference regarding whether or not continuity was viewed as being facilitated. It counted as facilitating continuity whether the attempt was a written letter, a phone call, or a home visit, as long as it was stated in the case record.

The data yield interesting results regarding this dimension of facilitating continuity. Out of a possible 132 clients, there were only 24 attempted contacts with clients who for some reason withdrew from treatment. It is to be noted that if the case record indicated any knowledge of the reason for a client's termination or any attempt to find out why he terminated, it was seen as facilitating continuity. Still, only 18.1 percent continuity existed regarding follow-up of self-terminated patients.
Continuity with Respect to Therapeutic Planning

The fourth and final indicator selected to use as a facilitator of continuity of care was that of therapeutic planning. This dimension was measured in terms of the amount of records containing treatment plans as well as regular ongoing planning contained in the progress notes. Also the termination summary was viewed to determine if it stated the treatment plans and how they were attained or not attained. No judgments were made regarding the type of therapeutic approach. The only necessary requirement was that it exist in the record.

As is evident in Table 1 in virtually every case record existed a treatment plan stating both the major aspect of the problem and the way the therapist thought the problem could be remedied. Continuity with respect to the ongoing treatment plan yielded a bit lower percentage continuity, but still indicated a very high degree of facilitating continuity. Although the percent continuity of care is very high with respect to therapeutic planning on both aspects, a significant point must be noted. Continuity was counted as being facilitated on this dimension even when a patient self-terminated as long as a treatment plan existed in the records and there was consistency in the progress notes along with an appropriate termination summary. Thus,
it must be pointed out that if continuity is to be viewed in its totality as a person completing a prescribed course of treatment, then it in fact does not exist even though there is a high percent of facilitating continuity regarding this dimension.

Intake and Staffing Continuity

Up to this point, the findings have been of those factors that are seen to be critical administrative dimensions of facilitating continuity of care. Intake and Staffing Continuity was seen to be critical in the actual implementation of continuity as it related to the initial needs of clients. It was measured with respect to intake and staffing by the number of recommendations to specific treatment elements that were in fact carried out.

The findings shown in Table 1 indicates that the actual implementation of continuity with respect to initial staffing is carried out in almost all cases. When it was not, the client refused to go to the next service element. From an administrative point of view, whatever the mechanism used, this dimension appears to be carried out. However, it must be noted that even though continuity is seen to be implemented, this says nothing of the quality of the care actually received. From the framework of this study however, which is only concerned with the administrative
dimension, continuity of care has a high percent with respect to this dimension.

Continuity of Movement

Continuity of movement was concerned with movement once the client was in an element of service. It was measured to the extent that clinical recommendations regarding movement from one element of service to another, in accord with therapeutic need, were in fact carried out. Since the day hospital is currently located in the hospital psychiatric wing and generally is used simultaneously with hospitalization, the elements viewed regarding movement were limited to inpatient and outpatient. For movement to be counted as being carried out in accord with continuity of care, the recommended change from one status element to another not only had to be recommended and implemented officially, but the case record had to indicate that the client had actually begun service in the new element.

There were 65 recommended changes or status transfers with 54 being carried out. This gives a final score of 83 percent continuity with respect to continuity of movement. When the direction of movement was from the center to the hospital, there is 100 percent continuity of care. The gap which does occur occasionally is when the recommended movement was from the hospital to the center.
Table 4 illustrates this difference. It is also to be noted that numerous clients when released from the hospital element of service were seen as receiving maximum benefits and needing no further service. These were viewed in this study as constituting continuity since what the therapists stated was taken as accurate. However, many of these cases seem to be the judgment of one person and not a result of a planning conference. One could seriously question whether continuity actually existed in these instances.

<table>
<thead>
<tr>
<th>TABLE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERCENT CONTINUITY WITH RESPECT TO THE DIRECTION OF PATIENT MOVEMENT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>No. of Cases</th>
<th>No. of Recommendations Implemented</th>
<th>Percent of Continuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Hospital to Clinic</td>
<td>25</td>
<td>14</td>
<td>56</td>
</tr>
<tr>
<td>From Clinic to Hospital</td>
<td>40</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
Continuity with Respect to the Referral Source

The findings concerning the referral source indicated that the private physician is the primary source of input to the community mental health center in Glasgow. Gray, when speaking of continuity with referring physicians, states that "the community non-psychiatric physician is not only an important referral source, but often the logical person to serve as the central coordinating source for continuity of care. This is, in fact, the long-standing model of continuity of care." \(^{123}\) Levenson also sees the family physician, who is the provider of any long-term supportive care, as an important element in psychiatric care. Care for the many psychiatric clients according to his view "can be most productive when it is set in the context of total medical care rather than being seen as an independent process exclusively focused on a mental disorder." \(^{124}\) The Regulations pertaining to the Community Mental Health Centers Act also advocates the cooperation and involvement of general practitioners as

\(^{123}\) Gray, op. cit., pp. 29-35.

\(^{124}\) Ibid., p. 30.
well as other non-psychiatric physicians. 125

In view of the low percent continuity regarding communication back to the referral source, it would seem appropriate that to emphasize this dimension, an administrative device would be set up and used that would extend well beyond the minimal requirement utilized in this study. However, for the moment, I will deal with the minimal requirement seen to facilitate communication with the referral source utilized in this study. Particular emphasis will be concerned with the private physician, since he is seen to be an integral part in the total health care needs of the client.

A minimum way for the administrative structure to communicate back to the referral source would be to standardize a form which would be sent back to the referral source when the client comes to the center. At present, the data in this study revealed a pattern of communicating only if information was requested by the prospective agency. (See Table 2.) In view of the fact that a permission for release of information is signed by the clients (see Appendix II), the center if it is to relate and exchange information with other agencies as it is mandated, could go beyond minimum contact. This would be true

particularly with family physicians who refer their patients to center services. However, a minimal requirement facilitating continuity could be a form which lets the referral agency know that contact was made and if they required further information, it would be sent upon request. Such a form is illustrated in Appendix III.

The organization of intake at the center provides a clue to the problem of lack of facilitating communication with the referral source. Gray,\(^{126}\) in his sample of centers, notes the diverse way centers handle the intake function. He states that in some centers, each element performs its own intake functions. Others provide a separate intake unit which serves as the focal point for outing incoming patients to the appropriate elements. At the Barren River Center, there is a separate unit called the Information-Screening-and-Referral Service. When a client has contact with the center, he is processed through this unit. The supervisor of this service has the primary responsibility to assess what is needed and make specific recommendations at the staffing the following morning. Different professionals may be involved in the actual intake process, but the responsibility for coordination is up to the supervisor. This person is an A.C.S.W.

\(^{126}\)Gray, op. cit., pp. 40-47.
social worker. After the staffing, the client is assigned a clinical person in the appropriate element of service and full responsibility for the client is assumed by the therapist assigned the case.

Regarding communication with the referral source, it is left to the discretion of the staff person assigned the case whether any contact is necessary or appropriate. If it is seen as critical to the needs of the client, this may be brought in the staffing. However, the actual implementation is up to the therapist. The decision then, whether or not any communication is to be made with the referral source, is essentially determined in a clinical context. It is not viewed as a total agency response to other sources dealing with the client, but rather as a clinical judgment based on a client's specific need at a specific time. This provides a partial answer to the reason for the low percent of continuity with respect to the referral source. It is not viewed as an administrative device which has the potential of facilitating continuity not only in the context of an existing client, but also for future clients. Rather it appears to have only clinical significance. This could explain the 100 percent continuity with respect to the referral source when the information was requested.
The lack of regular communication with referral sources does not appear to be unique in view of other community mental health center activities. Gray,\(^{127}\) in his national survey of centers found a very low percentage of centers who communicated regularly with the referral source. However, his survey indicated that 26.12 percent of the centers sampled, responded when the information was requested. This was his largest category of response. It must be kept in mind that his sample consisted of what centers stated they did but did not provide a statistical account of what centers actually did. From a personal standpoint, having worked in community mental health settings and having associated with professionals in numerous different settings in different geographic locations, there is often a discrepancy in what people state or even think they are doing, and what they actually do. Thus, another dimension calling for the need of this type evaluation.

The form already mentioned and illustrated in Appendix III, suggests a minimal way of maintaining communication with other agencies. However, minimal, it has the potential of a more systematic way of assuring ongoing communication with referral sources, and could be of ultimate benefit to current and potential clients. Its

\(^{127}\)Gray, \textit{op. cit.}, p. 25.
applicability to being monitored is particularly crucial and will be elaborated on later in another context.

Finally, since the private physician is seen to be crucial in terms of the total health care needs of clients, a further step, which goes beyond minimal administrative communication would seem to be appropriate. Information regarding the problem and proposed solution could automatically be sent back to the family physician on admission to center services. Also a termination report would provide the family physician on the up-to-date progress of the patient. This has many potential benefits both for the client as well as the community mental health center. First, it would provide the physician with up-to-date psychiatric information about one aspect of the client which he sees regularly regarding health care needs. Second, it gets at educating the general practitioner to the concepts of mental health which may be beneficial to this client or other clients in the community. Third, it decreases potential barriers between different potential groupings. Fourth, it can be used as an ongoing device to educate the physician as to the type of referrals which are appropriate. Finally, it tends to increase the visibility of the center. Thus, many clients who otherwise may not reach the mental health center could get needed services.
Continuity with the Referred Source

Continuity with the referred source was examined because discharge from one agency often means referral to another agency for additional services. There would seem to be many cases in which the major responsibility of the Mental Health Center is to increase the patient's social functioning to the degree which will enable another agency to be of service.\textsuperscript{128} If continuity means the completion of all services involved in the integrated plan for the patient, then the Mental Health Center's responsibility does not end when the center completes its service, but to see that the patient is integrated into the next logical subsystem of the plan.\textsuperscript{129} Again this says nothing of the quality in which care is rendered, but does indicate a minimum for facilitating it.

An important problem that needs to be resolved is whether or not the center has a low referral rate out of the center or if more referrals should have been made and were not. This would of course indicate a break in continuity. Whether or not more referrals should have been made is a clinical question and would constitute another study. However, in terms of facilitating continuity

\textsuperscript{128}\textsuperscript{Gray, op. cit., p. 72.}

\textsuperscript{129}\textsuperscript{Ibid., p. 72.}
organizationally, which is the concern of this investigation, some impressions are noteworthy. The region from which the cases were drawn is largely rural and the sophistication of specialized services is minimal. Many of the cases which have applicability to child welfare services or public assistance services have in fact been referred to the center from those settings. However, it has already been discussed that it is the responsibility of the center to see to it that the integrated plan is carried out, even to the point of linkage with other agencies. Consequently it seems logical that many cases would be referred back to the referral source for continued services. A plan with specific recommendations could be made as to what might further the progress of the client. Even if the client is terminated from center services as being improved and needing no further treatment at the center, it has been suggested that some check be made at a later date to determine if the client is continuing to do well. Similar to continuity with the referral source, the center study does not differ markedly from the national sample of centers surveyed by Gray in 1969. Fifteen centers, or a little over one-third of his sample leave continuing care possibilities strictly up to the client, and the agencies stating they exercised the initiative comprise only 14.6 percent. The remaining centers reported that
procedures at their centers were utilized as needed. However, having worked in mental health centers and being acquainted with numerous professionals who care currently involved in ongoing programs, it seems safe to assume that those centers who state they utilize procedures as needed do not necessarily have a built-in administrative device for this purpose.

Since there is a low percent of people being referred out of the center to other services, and due to the fact that the center has a vast amount of specialized services, it could be that those actually needing other services at the time of termination is low. It must also be remembered that the percent of self-terminated clients who did not notify the center was 51 percent. Perhaps these clients needed some other service which the center did not offer. This is only a possibility, but could provide the basis for a future study.

The way in which the center structures itself could provide clues to the lack of communicating back to an agency continuing to see the client due to other needs. At the Glasgow center, once the client has been assigned to an element of service, any contact with the referral source would have to be initiated by the therapist. Likewise, if there is to be information sent to another agency, whether due to termination, referral to another source, or
attempted linkage back to the agency which referred, it must come from the staff member assigned the responsibility. There is no administrative set-up to insure that this task is accomplished. It is solely up to the staff member assigned the case.

Two alternatives exist regarding the findings on continuity with respect to the referred source. First, it could be that referrals are not being made which are clinically appropriate and should be made. This would represent discontinuity and the high percent together with the low number of cases would be inaccurate. Second, it could be that referrals to other agencies are not needed because of the diverse services available at the mental health center. However, this leaves out the need to refer back to the referral source for continued service. Since this investigation is primarily oriented toward organizational factors that facilitate continuity, it is suggested that restructuring the approach to communicating to referral sources might lead to greater linkage and awareness of referral possibilities. This idea will be elaborated at a later stage.

An additional bit of knowledge worthy of note is Gray's analysis.\cite{gray130} He attempted to assess centers'

\cite{gray130} Gray, op. cit., pp. 73-74.
acceptance of responsibility for seeing that linkage with the referring source is established. In his questionnaire, he asked the question, "How do you refer patients to other agencies?" The respondents were given four choices: (1) by letter, (2) by phone, (3) by conference, and (4) other. His data indicated that 65 percent of all the centers studied use all three methods. Only 9.8 used letters and the telephone. When the responses were combined, 85 percent used conferences at least part of the time. In this study, the small number of referrals, according to the case record, were referred via letter and phone. In contrast to Gray's study, however, there appears to be little use of conferences between agencies serving the same client. This does not mean that the centers used in Gray's survey did not report what actually happens, but does point out again the necessity for quantitative investigations.

Continuity of Follow-up

The findings regarding follow-up of clients who appear to be leaving treatment before they are clinically assessed as ready, seem to be very significant due to the value that community mental health centers give priority to follow-up. The notion of follow-up, from the standpoint of the Joint Commission was practically synonymous with continuity. The 18.1 percent continuity found in this
investigation required only an attempt on the part of the center to find out why the client was terminating treatment. The client did not have to return to treatment to be counted as an application of facilitating continuity. Only an attempt, as indicated in the case record, was required.

A look at the existing organizational arrangements provides a clue as to potential reasons for the low percent of continuity with respect to follow-up. The organization of intake was already discussed regarding continuity with the referral source. If the potential client comes to the center for help and does not return for his next scheduled appointment after having been staffed, it is up to the staff member assigned the case to initiate any follow-up. All staff members when interviewed regarding this dimension stated that they generally call the person or write a letter to the client. No one stated that the responsibility was entirely up to the client seeking service. However, some felt they were lax in this and that the record probably did give an accurate account of the extent to which attempted outreach for client retrieval occurred. When the client actually comes to treatment after assignment to a staff member, but at a later date terminates treatment, the responsibility for follow-up, is with the staff assigned the case. Also, there appears to be no built-in check to insure that it does in fact occur. This suggests the
possibility that some systematic check would be of benefit to the staff assigned the case. This is not to imply that individual therapists do not see the need for follow-up, or that some do not carry it out consistently. Rather, it suggests that when left solely to the therapist who is already overburdened with numerous clinical responsibilities, the chance of follow-up is likely to occur. Perhaps this type of task could be assigned to a specific staff member and some built-in monitoring device utilized to insure patient follow-up when he drops out of treatment.

There also remains the possibility that the low percent of continuity of follow-up according to the case record is not an accurate account of what actually happens. One important piece of evidence suggests that this is not the case. In most all cases where the client self-terminated, the therapist writing the termination summary (Table 1) reports that the client for some unknown reason has discontinued coming to the center for service and the case should be terminated. When the client had been contacted or at least an attempt was made, it was noted in the termination summary. Although the cases were not categorized by individual therapists, it could be that individual therapist differ with respect to their attitudes toward continuity of follow-up, or some are simply unaware of its significant implications. In either case, if there
existed some administrative arrangement to insure that follow-up occurred rather than leaving it up to individual staff assigned cases, organizationally it would facilitate follow-up. An illustration and its applicable potential will be elaborated later.

This finding on a dimension seen by professionals in community mental health centers as crucial confirms even more Pollak's notion that if continuity is to be achieved, not only must the administrative structure facilitate continuity, but programs must be assessed to determine if it is in fact is carried out. It is one thing for 58.5 percent of centers surveyed by Gray to state that they maintain contact with clients by utilizing a combination of letter, phone, and home visits, while 9.8 percent use other combinations of these methods, and another matter to actually carry out the recommendation when they are appropriate.131 This is not to imply that Gray's respondents reported inaccurate information about the center's activities, but to concur with Pollak that actual tests must be carried out to determine if program activities which facilitate goals are in fact carried out. Other findings of Gray's survey regarding how centers maintain contact with clients, revealed that 50 percent of the centers (twenty)

131Gray, op. cit., p. 77.
utilized a combination of the agency's initiative together with the patient and the other agency's initiative.

Until tests are carried out, this could mean that centers think that is what they are doing, or think that is what they ought to do.

In Gray's survey,\(^{132}\) 7.3 percent leave the initiative for follow-up to the client. This means that most centers in his study do recognize the need of follow-up and maintaining contact with clients. After participating in staff conferences and talking with staff about this dimension, it is apparent that the center recognizes the need for follow-up and sees it as beneficial to clients. Some feel that it is done individually most of the time. Perhaps the findings of Gray's survey only represent a philosophical orientation on the part of the professionals in the centers and not an application of continuity of follow-up. Although this study, being a case study, cannot generalize the findings to other centers with structurally different arrangements in different geographical locations, it certainly suggests a need for further evaluation of other centers to determine if they are doing what they intend to do.

\(^{132}\)Ibid., p. 76.
Continuity with Respect to Therapeutic Planning

The findings related to therapeutic planning indicate a high percentage of continuity. However, this facilitating aspect of having information available in the case record must be reviewed in the proper perspective. Previously, it was noted that continuity of therapy is maintained to the extent that communication is maintained between the staff of different services. Although much of the communication is verbal, the case record serves a larger purpose than the immediate communication among staff. The philosophy of community mental health centers is that it serves as an ongoing resource with continuing knowledge of the people it serves. Thus, a client may return periodically to the center for services without getting the same routine informational questions relating to the status of his past. Part of the rationale for the significance of therapeutic planning being contained in the records is not only to facilitate continuity in the immediate life of the client, but to provide an ongoing basis of facilitating continuity. When a client returns to the center, care will be picked up where it left off. Much of the information concerning the client should already be in the written record and thus avoid unnecessary explanation with regard to client needs. The Schwartzes
refer to this type of continuity as a relationship with an organization. They state that "though the patient sees different helpers and is given a variety of treatments and services over a period of years, the organization, itself, may approach his particular needs in an integrated way. Hence, coherence and consistency make for continuity of care. As a result of this type of continuity as viewed by the Schwartzes, Levenson\textsuperscript{133} notes that over a period of time the client will develop a feeling of belonging and identify the center as "my center." This of course will be a direct result of the relationship he has had with the center. Therapeutic planning when placed in the case record is a significant aspect of fulfilling this goal and the high percentage with respect to this dimension is encouraging for appropriate care.

From the standpoint of the above, the high percentage of continuity is meaningful to the center to fulfill its goal of providing clients the opportunity to identify with an organization which is able to serve many of their psychic needs in their own community. However, as this relates to the overall results of this study, and when viewed in light of the dimension of follow-up, its

limitations are noticeable. All of those cases which lacked continuity of follow-up but had a termination summary with treatment goals and rationale were given a plus from the standpoint of therapeutic planning. This means that although continuity in terms of a prescribed course of treatment being achieved did not exist, therapeutic planning did in fact occur. The fact that continuity itself was not implemented was due to lack of follow-up.

As a result of the findings regarding therapeutic planning, one's interpretation of its significance is totally dependent upon the way one conceptualizes the purpose behind therapeutic planning as written in the case record. If its major intent is to facilitate appropriate care in terms of present needs, its limitations are noticeable if other dimensions of continuity are not implemented. On the other hand, if therapeutic planning is viewed in terms of its ability to facilitate appropriate care actually given to clients, in this investigation it fails to do so. Perhaps from this framework more time and effort should be expended in writing clinical records. This ultimately involves a question of priorities and must be determined by center personnel.
Continuity of Intake and Staffing

In regard to intake and staffing continuity, analysis of the ongoing process will provide a clearer picture of the results that were found; namely, that in virtually every case, continuity with respect to this dimension was found to exist.

When a potential client comes to the center for services, he is seen initially by the intake worker and an application is taken. This application can be seen in Appendix III. The interview begins with the application form and ends with an evaluation statement. The worker discusses the case for further therapeutic recommendations and implications at a staffing following morning. This staffing is composed of an interdisciplinary team which consists of a psychiatrist, psychologist, social worker, and psychiatric nurse. The social worker coordinates the efforts of the different team members. Diagram I illustrates the structure of this meeting. The results of the staffing is to assign the case (if appropriate) to a specific element of service as well as to a specific therapist. The therapist then, as was indicated earlier, has total responsibility for follow-up of this client throughout the treatment process within that element. What is important here as far as intake and staffing
DIAGRAM I

STAFFING PATTERN OF INTAKE
continuity is concerned, is that the client actually gets to the element of service.

Although an extremely high percent continuity was found regarding this aspect, unless placed in proper perspective, a center might assume it is achieving something which in fact it is not. First, there is the possibility that the clinical decision made is not always the most appropriate one. Even though the chance of this is minimized by involving an interdisciplinary team with differences in professional orientation, there remains the possibility that educational differences do not necessarily produce different theoretical orientations. Second, the fact that a client arrives at the appropriate element of service and is an indication of continuity, does not guarantee that he will stay the length of time required for him to receive maximum benefits. A study which would follow-up those who got to the appropriate element would be beneficial. The evidence as regards continuity of follow-up suggests that getting to the appropriate element of service is not sufficient for a client to continue treatment. It further says nothing about the quality of care actually received. However, it is a precondition both for continuing treatment as well as quality service, and client improvement.
Another factor which is significant in differentiating the low amount of self-termination before the person actually enters the element of service as opposed to when he is involved in treatment, is the element of follow-up. It is important to recall that continuity of follow-up was measured to the extent that an attempt was made on the part of center personnel to retrieve or find out from the patient his reason for dropping out of treatment. Follow-up was seen to have a very low percent continuity among those patients who dropped out of treatment. Perhaps a closer look at those cases which initially got to the appropriate element of service would reveal differences in patterns of follow-up after initial staffing. This is conjective but appears to be an appropriate area for further exploration.

Finally, it is extremely important that continuity with respect to intake and staffing be viewed as the partial (but important) dimension it is, if it is to be beneficial to the overall existence of continuity of care within mental health centers.

Continuity of Movement

The final dimension related to continuity was concerned with client movement from one element of service to another. Similarly to the intake and staffing, the client
must begin treatment in the new element for continuity to have existed. The two elements utilized for this study were those recommended changes from inpatient status to outpatient status, and from outpatient status to inpatient status. The 83 percent continuity with regard to this dimension suggests the possibility that similar to intake and staffing, follow-up occurs a greater amount of time. This aspect would provide the center with useful information about the effect of follow-up.

When client movement was from the Center to the hospital, the case record generally contained an elaborate analysis of the treatment process, and there was 100 percent continuity. This did not occur when the movement was from the hospital to the center. There are some indications why the percent continuity was not as high regarding movement from the hospital to the center. According to the case record, (there was) seldom an extensive termination summary. The commonly used statement on the termination summary was "client received maximum benefits." Although the treatment plan stated the nature of the problem and the need for hospitalization in all cases, the termination summary which was viewed as part of therapeutic planning, did not always contain the means taken to achieve the goal or any minimal statement of why it did or did not work. It also seems significant that in no case was there a specific
recommendation that the case be followed up with another element of service. The cases which were continued in outpatient services from the hospital ward appeared to have been initiated by the staff in outpatient service. This was done even if the client was initially staffed into the hospital element of service. It would seem that when the client entered the hospital after intake and staffing, the person seeing the case would attempt to involve the client and another element of service in some type of aftercare. This is in line with the casual implications of the notion of continuity of care as discussed in the review of the literature. However, from the written records, it appears that this was never done.

An analysis of client movement from the hospital to the center and from the center to the hospital provides insight into this apparent difficulty. First, where there seems to be no gaps in movement, that is, from the center to the hospital, the administrative arrangement appears to be more conducive to facilitating continuity of movement. The therapist who has been assigned the case is responsible for insuring that the client actually gets to the hospital if it is clinically appropriate. In other words, he is the person responsible for continuity of follow-up if continuity with respect to movement does not come about. Also, when he requests a change of service element from the
center to the hospital, the form seen in Appendix VI is not filled out until the actual admittance of the client into the hospital. A daily report is picked up at the hospital to determine who has been admitted and discharged. This report of names is shown in Appendix VII. If a client has been recommended to the hospital element by a therapist and actually arrives at that element of service, the form in Appendix VIII indicates that the patient is now in inpatient service. Thus, what happens administratively and officially and is contained in the written records is an accurate account of what takes place in practice. It also gives evidence to the one hundred percent of continuity that was found to exist with respect to movement.

A different picture occurs when the movement is from the hospital to the center. Here, on the form shown in Appendix VI, an immediate transfer change is recorded officially and placed in the written record upon discharge of the client. This change of status occurs before the client actually arrives at the next treatment element. What occurs in the record officially has not in fact happened. This is due to the demand by the state management information system being developed, that until a client is officially terminated he must have some recorded status within the center. In order for the client to reach the outpatient element of service, he must go to the clinic on
his own or be sought out by the clinic staff doing follow-up. The staff member ideally would have ongoing contact with the client while he is in the hospital even if the client went straight to the hospital after initial intake and staffing.

If the staff member has had little or no contact with the client, which he is supposed to follow-up, the way he gets the administrative information that the patient gets to the appropriate service is illustrated in Appendix VII. This contains those clients daily discharged. This register is written by medical records and placed on the bulletin board at the center. The sole responsibility is left to the therapist assigned the case. This form has recently been put in use and was not used in virtually all the cases in the study.

Up to the time the form was used, the patient was sent directly to the hospital, and upon discharge advised to come to the mental health center. Any linkage was dependent upon verbal communications among the different staff members in the different elements of service. Whether or not the new approach itself is working or fulfilling the needs of continuity of movement is a project for further study. However, one other element was added to this different approach. After the initial intake and staffing, and the client is recommended to be in a
separate element of service, the therapist assigned the case is to be responsible for it. Even if the client goes directly to the hospital, a staff member working in outpatient service is to continue to care for the patient while he is under medical care. This apparently was initiated to facilitate continuity. However, viewing this activity from an overall administrative viewpoint, it still places the sole responsibility for continuity on the therapist assigned to the case. It then becomes his responsibility to insure that it is carried out.
CHAPTER IV

SUMMARY AND CONCLUSION
Summary

This study has been an evaluation of the extent to which the Barren River Comprehensive Care Center facilitates and achieves continuity of care. Although two separate conceptualizations were viewed as valid ways of approaching continuity, the perspective of those whose primary responsibility is with planning and administering mental health services and the perspective of the recipient of service, this investigation dealt only with the former. The overall lack of continuity that was seen to exist from the selected dimensions viewed appeared to result from the structural arrangements that were set up to facilitate continuity. A proposed restructuring of the parts of the system and utilization of staff was suggested for implementation with appropriate monitoring. This "new system" which consists of new elements and the integration of the elements that already existed, were placed in the context of continuity of care and the responsibilities given to a specific unit of service.

Although the alternate conceptualization of continuity, that of the recipient of service, was not used in this study, it is suggested as a potential and valid area
for future study. Information regarding the client's perception of the type of service received would add to the total picture of continuity and enhance the potential for identifying factors which enhance client functioning.

Finally, it is suggested that once the system has been set up to facilitate and achieve continuity, it would then be appropriate and useful to determine if there is any significant relationship between those dimensions of continuity and the outcome of treatment for the client served. This, of course, is the ultimate test of continuity.

Proposed Restructuring to Achieve Greater Continuity

After evaluating the findings of selected dimensions as they relate to continuity of care, one aspect becomes very apparent. Most of the ingredients viewed as facilitating continuity are already being utilized in some form. What is lacking is the way the parts are combined and utilized to achieve the goal of continuity. There seems to be the view that whatever responsibility is given to a clinician regarding a client, it will be carried out regardless of the size or complexity of the tasks. For example, with continuity of follow-up, the administrative structure has no standardized way of attempting to
communicate with a client if he has in all probability dropped out of treatment. It is totally left up to the therapists with no built-in mechanisms to remind, monitor, and control whether or not it is actually carried out. It is not that clinicians at the center do not see the value of being monitored and controlled with respect to administrative dimensions relevant to client care, but rather the allocation of tasks and responsibilities often-times are so diverse and numerous that it becomes easy to overlook "routine" functions that ought to be done. For example, one clinician may be involved with a caseload, school consultation, speeches in the community, and liaison with other agencies. While these things in themselves are worthwhile activities, a large amount of activities in different areas with no functional limitations set, can overburden personnel and create role confusion on the part of staff. This "spreading thin" of oneself among staff coupled with the assumption of expertise in every area creates the lack of integration and inappropriate combination of different parts previously mentioned. Perhaps some of this is due to the problems associated with community mental health centers thinking they can be all things to all people.

As a result of the findings coupled with the problems associated with utilizing personnel in an optimum way
to achieve desired ends, I will propose a restructured system in which the Barren River Comprehensive Care Center could increase its effectiveness regarding continuity. The major components of the proposed revision is not new in itself—what is new is the framework from which the combination of parts is viewed coupled with a built-in mechanism to insure that the goal sought is continually being monitored and modified to fit existing needs. The focal points of the revised system are: (1) restructuring the Information-Screening-Referral services to be viewed in terms of the goal sought, namely, continuity of care, (2) utilization of existing personnel in terms of functional responsibilities with the recognition that functional tasks must be allocated in view of time and capability constraints, and (3) a heavy emphasis on managerial control to insure checks and balances and help determine if the desired activities are in fact carried out.

The first point which deals with the Information-Screening-Referral service, is best described in the initial staffing grant application of the Barren River Center.

The overall goal of the Information-Screening-Referral service is to facilitate and assure continuity of care whenever possible. When the patient has his first contact with the center, it is the responsibility of the ISR to see that the client (the input to the Center) is put in contact with the appropriate source
of help if it is clinically indicated. This help may be a service within the Center or in another agency. Whichever it may be, the ISR responsibility of follow-up to assure that the patient actually received the help that was clinically indicated. Further, since the referral source is often viewed as a significant factor in the life of the client, it is necessary that he receive information regarding current condition of the client. (This was previously seen to facilitate continuity.)

The ISR service will provide a clearing house of community services with information available on the telephone for inquiries about services, and with referral services when an appointment in the Center for definition or delineation of the presenting problem is not indicated. It will also provide 24-hour assistance to patients and families, and to physicians requiring psychiatric consultation, an availability factor which should greatly enhance the possibility of local physicians shouldering a more substantial share of care for psychiatric patients in their own communities.

In addition the ISR service will provide ongoing liaison and support to other related professionals who need assistance to cope with mental health problems of students, welfare recipients, homebound medical patients and others where emotional problems being met by the agency requiring consultation.

The ISR, through maintenance of central records, will preclude duplication of efforts, will assure continuity of care for patients and provide people with a single resource which will assure them of service. Records will be filed under social security numbers, rather than names, for purposes of confidentiality and in keeping with the system already instituted by the Department of Mental Health in the state facilities. Records will be transferrable with patient approval, and staff responsible for a patient's care in one element of service as long as it is not clinically contraindicated.134

Thus, the responsibility of the ISR is a total one involving every aspect of care that may be conducive to client needs. The wording of ISR in its day-to-day operation,

134 Application for Staffing Grant, Region VII, Mammoth Cave Comprehensive Care Center, 1967.
does not make one totally aware of the goal sought. ISR as it is currently operating, is but one unit function within the total concept of continuity of care. Oftentimes those involved in the ISR service are not aware of its total implications and consequently see the goal as Information-Screening- and Referral. This helps explain why the ISR service can carry out its activities as stated in its name and yet not be conducive to continuity. This was seen with respect to continuity with the referral source. Consequently, the first aspect of the proposed change is to rename the ISR services within the context of continuity of care. This would free the practitioners carrying out the activities of that service from seeing those activities as an end in itself. It would then allow them to view the ISR services as only one component in combination with other components enabling mental health centers to achieve the goal for which the activities were originally designed to achieve. Diagram II illustrates what has been happening and Diagram III illustrates the proposed framework.

The proposed name change would broaden the functional responsibilities of this unit but would bring about an increased awareness of its function in relation to the goal sought. This of course has many more practical implications for patient care and will be elaborated and integrated with the other components later in the analysis.
DIAGRAM II

CURRENT MOVEMENT OF INFORMATION RELATED TO THE CLIENT

Patient Contacts Center

Intake Screening
- Telephone
- Walk-in
- Interview

Information Collection
- Application
- Medical
- School
- Agency

Information Giving
- Other Treatment Facilities

Staffing

Therapist
Therapist
Therapist
Follow Through Termination
PROPOSED MOVEMENT AND CONTROL OF INFORMATION RELATED TO THE CLIENT
The second proposed rearrangement concerns the utilization of staff for specific tasks. Currently the ISR services are delivered by a variety of staff and coordinated by a single staff member. However, this coordination is more of a loose structural component with a designated staff person who has numerous other clinical responsibilities that make the complex tasks equated with the ISR a practically impossible task. What appears to have happened in practice is that many clinical staff members are called upon to fill many roles and one has been designated to coordinate the activities of all. This designated position has not been specified in terms of functional tasks. Consequently, the designated head of ISR has simply been the ultimate responsibility for clinical activities within the Center. The proposed Continuity of Care Team would have a supervisor whose activities would be for the most part, if not totally, outside direct treatment services. The primary task of the team after specifying the activities that are conducive to facilitating continuity will be to monitor administratively those critical elements from the time a client has contact with the Center until he is discharged or in contact with another agency as a result of referral.

This brings us to the third focal point of the proposed rearrangement; namely, the emphasis on administrative control to insure checks and balances in the system. The
Continuity of Care Team Supervisor will monitor the specified activities related to continuity both in terms of input to and through the Center as well as anything related to continuity going as output from the Center. The format for the flow of information and it being controlled and monitored by the Continuity of Care Team has been illustrated in Diagram III. What is particularly significant and different from what has been done, is to single out a given unit of activity and give it the specific function of insuring that those activities which relate to continuity are in fact carried out from the time the potential client has contact with the Center until he no longer needs any type of service. The Continuity of Care Team controls and monitors both the input and output of the Center. The specific activities which could be utilized as accountable work tasks could be selected dimensions relating to continuity and studied in this investigation. Others could be added if found to be appropriate, or modifications made when necessary.

For example, the Continuity of Care Team could be held accountable for the implementation and monitoring of continuity with the referral source, continuity with respect to therapeutic planning, continuity regarding intake and staffing recommendations, continuity of follow-up, continuity with respect to movement, and
continuity with the referral source. Thus the functional requirements allocated the Continuity of Care Team would be activities that are seen to facilitate and maintain continuity of care. This would remove from clinicians tasks which they generally see as "bureaucratic" requirements, and free them toward activities totally related to the clinical needs of their clients. It would move all administratively oriented activities into a single unit with specific functional tasks for the members of the team.

The members of the Continuity of Care Team is illustrated in Diagram IV. All activities of the team members will be supervised by the Continuity of Care Supervisor. The primary responsibilities of this position is that of monitoring the dimensions related to continuity. Many of the simple nonclinical tasks which have or should have been done in the past by overburdened professionals could be allocated to the Continuity of Care receptionists. These tasks coupled with proper procedural forms would not only be more conducive to continuity, but would create a more efficient and manageable system.

The responsibilities of the Continuity of Care Team Intake Receptionists would be as follows:

1. Telephone Calls.
   (a) Supply requested information.
DIAGRAM IV

PROPOSED STRUCTURE OF CONTINUITY OF CARE TEAM

SUPERVISOR

Continuity of Care Receptionist

Area Team Leader

Mental Health Associate  Mental Health Associate

Intake Worker

Area Team Leader

Mental Health Associate  Mental Health Associate
(b) Make immediate referral when indicated (to a professional staff person, other agency or individual.

(c) Schedule an interview with the appropriate professional person and notify client of his appointment time.

(d) Fill out a Continuity of Care Information-Screening contact card. This is illustrated in Appendix VII. (It is to be noted that this form has been devised at the State level but is not mandatory for Centers to use it.)

2. When deemed necessary by the Continuity of Care Team telephone the client to remind him of his appointment at the Center. Or, if the client has been referred to another agency, to remind him of that appointment. In that case, follow-up with the agency referred to, to see if the appointment was kept. This is in accord with assuring implementation of continuity of follow-up.

3. When a client arrives at the Center for his first face-to-face interview with a professional staff member of the Continuity of Care Team:

(a) Complete the Application Form. This is a form devised by the State and is currently being used by the Center. (See Appendix IV.)

(b) Complete a Permission for Treatment/Service Form. (This is a State Form currently in use by the Center.) See Appendix II.

(c) Fill out a Service Ticket. (See Appendix VIII.) This form provides relevant information about the client which is sent to the state management information system and used for comparative purposes about Center activities.
(d) Prepare a plain manilla folder to contain materials collected during the evaluation process. This is the major source of written information and is housed in the medical records department of the Glasgow Center.

(e) Give the folder to the staff person seeing the client. (If the client is scheduled to be seen by a staff member other than at the Glasgow office, a complete description of the service being requested should accompany the folder.)

(f) Notify the referring source that a client has been seen and what treatment is planned. (Note that this is continuity with respect to the referred source.)

4. Arrange appointments for initial and continuing evaluation with supervision of the Continuity of Care Supervisor. (This is in accord with the element of therapeutic planning.)

5. Keep the Continuity of Care Information-Screening Card or the Application Form current until such time as a final decision is made (listing telephone calls, additional screening, etc., on back of card.) This is part of monitoring continuity of follow-up.

6. Upon completion of the evaluation, the receptionist will receive from the Continuity of Care Team Supervisor, the client's folder for review of material contained therein, to determine if all necessary items are included. (This, of course, is monitoring continuity with respect to referral
source, continuity of follow-up and continuity with respect to therapeutic planning.)

7. If the client is referred to another agency, facility or professional individual:

(a) Send the necessary materials to the referred agency. (This is continuity with respect to the referred party and assumes both continuity at intake and staffing, and continuity of movement if applicable.)

(b) Prepare Referral Notice Form in triplicate. (See Appendix IX.) Send original and one copy to the source and retain one copy for file.

(I) If a form is returned indicating that the client has not kept his appointment, the receptionist notifies the staff person responsible. The receptionist then does the necessary follow-up work with the client to determine why the appointment was not kept, and attempts to make a new appointment. (This is another aspect of continuity of follow-up.)

(c) See that the client's folder is given to the Medical Records Department.

8. If a client has been staffed and accepted for treatment, all information and data is given to the Medical Records Department for further processing.

9. Enter the client's disposition on the Continuity of Care Contact Card and file. This information is readily available to the Continuity of Care Team.

10. When a client fails to keep his initial appoint-
(a) Send a form letter to the client asking him to call if he wishes further service. (See Appendix X.)

(b) Send a form letter to the referring source advising them that the client did not keep his appointment. (See Appendix III.)

(c) Indicate both (a) and (b) above the Continuity of Care ISR contact card and report this to the Continuity of Care Supervisor.

11. At the regular staffing,

(a) Notify each professional which clients failed to come in and what letters were sent out.

(b) Notify each professional of his schedule of appointments for the next week.

The responsibilities and tasks of the Continuity of Care Intake Receptionist frees professional time consuming activities while simultaneously, with the use of integrated forms and procedures, creates the potential for those activities to be monitored. Since the primary tasks have been simplified and are put in motion by the intake receptionist, the Continuity of Care Supervisor is free to actively monitor the system. At the same time the standard activities used in relation to continuity may be subjected to clinical judgment by the Supervisor. For example, under certain conditions it may be viewed as clinically beneficial to write a personal letter or make a home visit instead of the usual procedure. However, at least there is the minimal assurance of facilitating continuity as it has been viewed in this study. Also, it provides a minimal
structural base which could be elaborated as the needs are indicated.

In conclusion, although the suggestions made will increase managerial control and allow quantitative analysis regarding dimensions related to continuity, extreme caution is warranted. Etzioni\(^{135}\) notes that the very effort to establish how goals are being met and ways of measuring them can produce undesired effects. The organizational goal can be distorted by frequent measuring because some aspects of its output are more measurable than the others. Frequent measuring tends to encourage overproduction of highly measurable items and neglect of others.

What needs to be done as a result of this investigation is to compare a group of community mental health centers on the dimensions of continuity. This comparative analysis would provide more meaningful quantitative data in regard to continuity. Also, there needs to be studies which explore the relationship of factors seen as critical to continuity and improved client functioning. Finally, the consumer of mental health service should be involved in any ultimate test of continuity and its relationship to improved client functioning. It may well be that until an empirical relationship is demonstrated between the factors

of continuity as viewed by the planners and providers of service, and improved client functioning as determined by the client, the notion that planners have of continuity and its relationship to client functioning may be erroneous.
APPENDIX I
MAP OF KENTUCKY
REGION IV
AREA STUDIED, 4B
APPENDIX II

PERMISSION FOR TREATMENT FORM

Comprehensive Care Center
of the
Mental Health-Mental Retardation Regional Services

ADDRESS

DATE _______________

PERMISSION FOR TREATMENT/SERVICE

Permission is hereby given to the staff of the COMPREHENSIVE CARE CENTER to render treatment and/or service to:

whose relationship to me is (Check one):

___ Self  ___ Spouse
___ Child  ___ Other (Specify) _______________________

Signature of Patient or Client

Signature of Patient's or Client's agent or representative

Relationship

Address

WITNESS ____________________________  DATE _______________

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APPENDIX III

REPORT FORM TO REFERRING SOURCE

DATE: ____________

____________________
____________________
____________________

RE: ____________

____________________
____________________
____________________

ADDRESS

FOR YOUR INFORMATION:

Following your referral, the above named patient

__ 1. Is being seen for outpatient care. Should you need information regarding this patient, please call us at ____________.

__ 2. Has been seen by the staff and has been referred to __________________ for the following services: Physician/Agency

____________________
____________________

__ 3. Has been contacted for ______ appointments but has failed to come in.

__ 4. Has been contacted by the Center but refuses to accept an appointment.

__ 5. Cannot be reached at the address furnished.

Sincerely,

____________________

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APPENDIX IV
APPLICATION FOR TREATMENT FORM

Date of Application

Region   Unit   Social Security No.

Last Name  First  Middle  Sex  Race  Age

Birth Date  Birth Place

Present Address (No., St., City, State, Zip Code)

Census Track  County  Phone No.

Permanent Address

Nearest Relative (Relationship, Address)  County  Phone No.

Responsible Party (Relationship, Address)  County  Phone No.

Notify in Case of Emergency (Relationship, Address)

Education (Grade/School)

Religion  Church (Name, Address)  Minister

Source of Referral (Name, Address)
Other Person/Agency Consulted (Name, Address)

Name of Father          Dec.          Birth Place

Maiden Name of Mother   Dec.          Birth Place

Marital Status          No. of Children

Dates of:
Marriage                Divorce
Separation              Widowed

Previous Marriage
To: ______________________ Date: __________

M/F  Relationship  Birth Date  Education (Grade/School)  Med./Hosp. Treat (Last 12 mo.) (Include MH-MR Treatment)

Previous MH-MR Treatment of Patient

INPATIENT          OUTPATIENT
Facility  Dates  Facility  Dates
Physical Condition (Specify, Indicate if Treatment is Being Received):

Name, Address Family Physician

Presenting Problem:

Disposition:

Assigned Pt. Status:

Therapist Assigned to:

FINANCIAL DATA

Patient Responsible Party

Length of Ky. Residence No. of Dependents:
Veteran: ___ Yes ___ No

Claim No. Serial No. Other

Occupation:

Who (Pt./Others):

Employer (Address, Phone):

How Long No. Income

Insurance (Name, Address):

Sub. Name: Policy No.

Group No.: Eff. Date:
Medicare No.: _____________________________________

Med. Assistant Ident. No.: ______________________

Self Pay:   ___ Yes   ___ No

Other (Specify): __________________________________

Rent:       ___ Yes   ___ No

Own Home    ___ Yes   ___ No

Market Value of Home: ______________________________

Amt. of Mortgage: _________ Other (Specify): _______

Bank (Name and Address): _________________________

Checking Account:   ___ Yes   ___ No

Amount: _______________

Savings Account:   ___ Yes   ___ No

Amount: _______________

Other Investments (Specify): _____________________

Amount: _______________

Annual Family Income: _______________

Established Fee: _______________

_____ Can Pay Full Cost of Service

_____ Can Pay Part of Cost of Service

Added Comments: ___________________________________

_________________________________________________________________
APPENDIX V
CHANGE OF TREATMENT FORM

File Number

INTERNAL NOTICE
OF
CHANGES AND CORRECTIONS

Last Name  First  Middle

Date

CHANGE OF STATUS
FROM __________________________
TO __________________________

THERAPIST TRANSFER
FROM __________________________
TO __________________________
FROM UNIT __________________________
TO UNIT __________________________

ADDRESSOGRAPH PLATE
FROM __________________________
Correct TO __________________________
Replace (Attach Plate)

OTHER--SPECIFY: __________________________

TERMINATION
SIGNED __________________________
TITLE __________________________
APPENDIX VI
DAILY HOSPITAL REGISTER

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<th>PATIENTS ON WARD</th>
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<td>NAME</td>
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<tr>
<td>COUNTY</td>
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APPENDIX VII

CONTINUITY OF CARE CONTACT CARD

INFORMATION, SCREENING, REFERRAL CONTACT CARD

CONTACT: Phone ___ Visit ___ Other (Specify)

DATE ___________ CROSS REFERENCE: ____________________________

(Last Name) (First) (Middle) AGE ________________

BIRTHDATE ___________ SEX _____ RACE ______________

MARITAL STATUS ___________ SOCIAL SECURITY NUMBER _____________

RESIDENCE TELE. # _____ BUSINESS TELE. # _____

PRESENT ADDRESS
(Number, Street, City, State & Zip Code)

COUNTY _________________

PERMANENT ADDRESS
(No., St., City, State & Zip Code)

COUNTY ___________ RESIDENCE TELEPHONE # ______________

NEAREST RELATIVE ADDRESS ________________ TELEPHONE # ______________

RELATIONSHIP ________________ SOURCE OF REFERRAL _____________

FAMILY PHYSICIAN _____________ DATA DISCUSSED ________________

RESULT OR PLAN: ________________________________

DISPOSITION: ________________________________

LATER CONTACTS: (give date & description) ___________________

NOTE: Use other side of card to give other information you consider to be helpful.

Personnel reporting
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<th>County</th>
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MENTAL HEALTH--RETDARDATION REGIONAL SERVICES

KY-CCC-1-5
APPENDIX IX

REFERRAL NOTICE TO OTHER AGENCIES

REFERRAL NOTICE

TO: ___________________ RE: ___________________

Last Name First Middle

(Address) NUMBER: ___________________

ADDRESS: ___________________

SENDER: ______________ PHONE NUMBER: ___________________

(Address) REASON FOR REFERRAL: ___________________

Phone Number: ___________________

__________________________

COMPLETE THE FOLLOWING AND RETURN PINK COPY TO SENDER,
ADDRESS ABOVE

APPOINTMENT MADE: ___ YES ___ NO

APPOINTMENT KEPT: ___ YES ___ NO

IF YES, DATE: ___________________

DISPOSITION (RESULT or PLAN): ___________________

__________________________

SIGNED: ___________________

Title ___________________ Date ____________

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Dear

You were referred to us for service by

__________________________________________________________

and were given an appointment for _________________________
on ____________________________________________________________.

Since you did not come for the appointment, we are inquiring if you still wish our service. If you do, please call us for another appointment. If we do not hear from you, we will close out your request.

Sincerely,
Books


Leighton, Clausen, and Wilson, eds. Explorations in Social Psychiatry. 1957.


Rose, A. M. Mental Health and Mental Disorder. 1955.


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