

Mental Healthcare in Rural Communities: The Once and Future Role of Primary Care

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The provision of mental healthcare in rural communities has been a vexing challenge for clinicians and patients for many years. There is a chronic shortage of specialty mental health providers, particularly psychiatrists and psychologists, which has shifted much of the burden of care to primary care. Primary care clinicians have historically lacked the training and time within their busy practices to feel comfortable providing mental healthcare, particularly since the shortage of specialty mental health clinicians deprives them of consultation and referral sources. People who live in rural areas must often overcome significant travel distances, stigma, and lack of insurance and other resources to access the scarce mental health services that do exist.¹

Despite this difficult picture, rural primary care and specialty mental health clinicians have persevered to provide some level of mental healthcare to people in rural areas. Over the last decade, improvements in clinical screening tools, treatment protocols and guidelines, and information technology have significantly enhanced the potential to increase access to and improve the quality of mental health services in rural communities, particularly to underserved populations. Recent policy initiatives hold much promise to provide the structural and financial support necessary to help rural communities realize these improvements.

In this commentary, we first present a general discussion of the issues related to the delivery of mental health services in the United States with particular attention to how these issues complicate the delivery of services in rural areas. Next we describe the renewed call for integrating primary care and mental health in rural areas (hence “the once and future role of primary care” in our title) and related clinical and policy support to do so. We close by briefly describing the policy interventions and resources needed to further these integration efforts and to improve access to services for rural underserved populations.

Our Fragmented Mental Health Delivery System

The mental health delivery system in the United States is characterized by a fragmentation of services, separation of funding streams and delivery systems, poor reimbursement, inadequate access to specialty mental health providers, and the mal-distribution of existing resources. These issues greatly complicate the delivery of services in rural areas.

The United States mental health system is not a coordinated system of specialty mental health services but, rather, a fragmented collection of services and providers that has come to be known as

“...60% of rural residents live in mental health professional shortage areas ... [and] ... 65% receive treatment for mental health problems from their primary care providers....”

the *de facto* mental health “system.”^{2,3} The term “system” is used to convey an understanding of where persons receive services, rather than to suggest a coherent whole that has developed according to a set of organizing principles.⁴ Regier and colleagues identified four sectors where individuals may seek assistance for their mental health needs: (1) *specialty mental health*, (2) *general medical/primary care*, (3) *human services*, and (4) *voluntary support networks*. Our discussion will focus on the first two sectors, which make up the formal treatment system in most communities.

The *specialty mental health sector* is made up of psychiatrists,

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psychologists, psychiatric nurses, and social workers practicing in various public and private inpatient, outpatient, residential, and community agency settings and is the sector that comes to mind when people think about mental healthcare. The *general medical/primary care sector* is made up of general and family physicians, pediatricians, internists, nurse practitioners, and physician assistants providing a range of healthcare services, including, but not limited to, mental health services.

Contributing to this fragmentation of services has been the historical separation of funding streams and governmental responsibility for oversight of service delivery. Mental health and substance abuse services have traditionally been viewed as separate and apart from the general medical system. These services have typically been reimbursed at lower levels than general health services and often through separate pots of money. The separation of funding streams continues through the use of carve-out programs by many state Medicaid programs and commercial insurance companies in which a behavioral managed care organization is responsible for the management and approval of mental health services. Responsibility for the oversight of the delivery of mental health and substance abuse services at the state level is typically housed in a separate state mental health agency. Some states further fragment these services by assigning responsibility for the oversight of substance abuse services to a separate substance abuse agency.

Populations Served

The delivery of mental health services has historically been based on the specialty care model in which mental health specialists treat mental health problems and primary care providers assess and refer patients to these specialists as necessary. The use of this specialty care model fails to explicitly acknowledge the reality that most people seeking mental healthcare fall into one of two broad populations.⁵ The first is the special population of adults with serious and persistent mental illness and children with serious emotional disturbances. The second population is the general population of individuals who frequently have more modest and episodic mental health needs (in comparison to the special population).

Members of the special population, who are often covered by Medicaid as a result of their mental health diagnosis and/or disability, are best served by the specialty care system and often require specialized services, such as congregate housing, vocational services, and crisis services. Members of the general population, whose needs may often be appropriately met within the primary care system, are often “encouraged” to seek services through the specialty mental health system due to reimbursement and/or health plan coverage issues. Given the separation of services and delivery systems, poor reimbursement rates, the reliance on the use of the specialty model by third party carriers, and the growing demand for services within the general population, the supply and distribution of specialty mental health providers and services are inadequate to meet existing needs, particularly in inner cities and rural areas.

The Special Challenges of Delivering Mental Healthcare in Rural Areas

Rural residents, like their urban peers, experience a wide range of mental health and substance abuse problems. National mental health epidemiological studies show little or no differences in the prevalence of mental health problems among adults across rural and urban areas.^{6,7} While the prevalence of mental health disorders is similar, the composition and context of mental healthcare is profoundly different in rural and urban areas.⁴ The New Freedom Commission on Mental Health (2004) suggested the following framework in which to consider these differences:

- *Accessibility.* Rural residents travel further to receive services than urban residents; are less likely to have insurance benefits for mental healthcare; are less likely to recognize mental illnesses and understand their care options; and enter care later, sicker, and with a higher level of cost.^{8,9}
- *Availability.* Rural areas have chronic shortages of mental health professionals (60% of rural residents live in mental health professional shortage areas); few comprehensive services; and providers that are physically isolated from each other and their patients.^{10,11} Rural residents rely more heavily on informal supports and indigenous healers than do urban residents and are more likely to be treated in a primary care setting (65% receive treatment for mental health problems from their primary care providers).
- *Acceptability.* Even when scarce services are available and accessible in rural communities, they may not be acceptable to people living in a rural area because of stigma, which is particularly intense in rural areas where anonymity is difficult to maintain; cultural issues; and limited or non-existent choice of providers.^{12,8}

In many ways, mental health providers in rural mental health systems are even more “de facto” than those in urban areas.¹³ Rural mental health practice is characterized by a lack of available services, scarcity of resources, severe shortages of specialized mental health practitioners and providers, the under-utilization of services, the impracticality of specialization, and a recognition that clients must be supported beyond the narrow range of medically necessary specialized mental health services.¹⁴

At present, more than 90% of all psychiatrists and psychologists and 80% of master’s-level social workers work exclusively in metropolitan areas, a workforce distribution that has remained remarkably constant over the years. This maldistribution has persisted for more than 30 years despite repeated efforts to overcome existing market forces and encourage more mental health providers to practice in rural areas. The failure of these efforts can be traced to the challenges faced by mental health clinicians who chose to practice rural areas. They are often called upon to treat patients outside of their fields of expertise, reach complex decisions without the advice of other professionals, interact with patients in a variety of nonclinical roles, and are

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subject to professional isolation and a high potential for burnout.^{15,16} Rather than wishing for resources that we don't have and that history tells us that we may not achieve, we need to develop a national rural mental health plan that rationalizes our current system and capitalizes on our existing strengths and resources.

The end result is that many rural Americans rely heavily on the primary care system as their source of mental healthcare.¹⁷ In fact, many rural residents express a preference for receiving mental health services through their primary care providers, given the issues of stigma and the perceived lack of confidentiality due to the small town environment (in which everyone knows your business). In many ways, these pressures are positioning rural communities to lead the way in developing rationalized systems of care in which primary care providers are an integral part of the mental health delivery team.

Renewed Calls for the Integration of Mental Health and Primary Care

Although discussions of the integration of primary care and mental health in rural areas date back to the early 1970s, a number of national reports and studies have signaled a renewed interest in and policy support for efforts to strengthen integration efforts among rural providers. The Surgeon General's Report on Mental Health acknowledged the crucial role of primary care in providing mental healthcare.¹ The President's New Freedom Commission on Mental Health (2003)¹⁸ promoted integration of primary care and mental health to help address access problems in rural areas. The National Advisory Committee on Rural Health and Human Services' Report to the Secretary (2004) and the national Institute of Medicine's Quality Through Collaboration: The Future of Rural Health Report (2005)¹⁹ call for integrating mental health with rural primary care. Mental health expansion and new access points grants, created under the President's New Access Initiative, provide funding for Community Health Centers (CHCs) to deliver behavioral health services.²⁰

Resources Needed to Enhance the Integration of Mental Health and Primary Care Services in Rural Areas

Over the past decade substantial progress has been made in developing tools and resources to support the integration of

mental health and primary care services. These tools and resources include a variety of screening tools, evidence-based practices, and best practice models. Legislative changes provide cost-based reimbursement for Rural Health Clinics employing doctoral-level psychologists and clinical social workers. The Bureau of Primary Health Care provides grant funding to support the development or expansion of mental health services by CHCs. The Bureau also supports the development of Health Disparities Collaboratives by CHCs using Ed Wagner's chronic care model to treat patients with chronic conditions including depression.²¹

It is no longer a question for a rural practice of how to get started but, rather, how to sustain these activities over time in a day-to-day practice setting.²² The delivery and coordination of mental health services in a primary care practice require a balance between the provision of integrative services (e.g., coordination with primary care providers in the practice as well as external specialty care providers, engaging patients in the treatment process, educating clinicians and staff, etc.), which are frequently not reimbursable and more traditional assessment and counseling services which are.²²

Additional tools and policy interventions are needed to further the expansion of these efforts. These include: (1) the development and implementation of electronic medical records to support clinical integration and communication; (2) continued provision of mental health expansion and new start grants by the Bureau of Primary Health Care; (3) the development of federal and state policies to compensate for the limited access to specialty mental health services; (4) support for the expanded use of telemedicine technology to provide access to psychiatric consultative support in rural communities; and (5) the provision of third party reimbursement and support for the delivery of mental health activities in rural practices, including reimbursement for integrative activities and the inclusion of these primary care practices in Medicaid and commercial behavioral managed care plans.

The integration of mental health and primary care services is a policy goal whose time has come. Due to long-standing resource constraints, rural communities and practices have led the way in developing integrated models of care, often in the face of limited financial and administrative support. For further progress to be made, we must acknowledge the challenges related to the integration of these services and develop policy interventions, training tools, and technical assistance to overcome them. **NCMedJ**

REFERENCES

- 1 US Department of Health and Human Services (DHHS) Mental Health: A Report of the Surgeon General. Rockville, MD: National Institute of Mental Health. 1999.
- 2 Regier D, Goldberg I, Taube C. The de facto US mental health services system. *Arch Gen Psychiatry* 1978;35:685-693.
- 3 Regier D, Narrow W, Rae D, Manderscheid R, Locke B, Goodwin F. The de facto US mental health and addictive disorders service system: Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry* 1993;50:85-94.
- 4 Gale J, Deprez R. A public health approach to the challenges of rural mental health service integration. In BH Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide*. Washington, DC: APA Books. 2003:95-108.
- 5 Lambert D, Gale J, Bird D, Hartley D. Medicaid managed behavioral health in rural areas. *J Rural Health* 2003;19(1):22-32.

- 6 Kessler R, Berglund P, Demler O, Jin R, Merikangas K, Walters E. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Arch Gen Psychiatry* 2005;62:593-602.
- 7 Kessler R, McGonagle K, Zhao S, Nelson C, Hughes M, Eshleman S, Wittchen H, Kendler K. Lifetime and 12-Month prevalence of DSM-III-R psychiatric disorders: Results from the National Comorbidity Study. *Arch Gen Psychiatry* 1994;51:8-19.
- 8 Wagenfeld M, Murray J, Mohatt D, DeBruyn J. Mental health and rural America, 1980-1993: An overview and annotated bibliography. Washington, DC: Department of Health and Human Services, US Public Health Service. 1994. (NIH publication #94-3500)
- 9 McDonnell K, Fronstin P. EBRI health benefits databook. 1st ed. Washington, DC: Employee Benefit Research Institute. 1999.
- 10 National Advisory Committee on Rural Health. A targeted look at the rural health care safety net: A report to the Secretary, US Department of Health and Human Services. Washington, DC: National Advisory Committee on Rural Health. 2002.
- 11 Bird D, Dempsey P, Hartley D. Addressing mental health workforce needs in underserved rural areas: Accomplishments and challenges. Portland, ME: Maine Rural Health Research Center, University of Southern Maine. 2001.
- 12 Rost K, Fortney J, Fischer E, Smith J. Use, quality, and outcomes of care for mental health: The rural perspective. *Med Care Res Rev* 2002;59:231-265.
- 13 Lambert D, Hartley D. Linking primary care and rural psychiatry: Where have we been? Where are we going? *Psychiatr Serv* 1998;49(7):965-967.
- 14 Beeson P, Britain C, Howell M, Kirwan A, Sawyer D. Rural mental health at the millennium. In Manderscheid R and Henderson M eds. *Mental Health*. Rockville, MD: Center for Mental Health Services, 1998:82-97.
- 15 Roberts L, Battaglia J, Epstein R. Frontier ethics: Mental health care needs and ethical dilemmas in rural communities. *Psychiatr Serv* 1999;50(4):497-503.
- 16 Beeson P. The successful rural mental health practitioner: Dimensions of success, challenges, and opportunities. *Rural Community Mental Health* 1991;18(4):4-7.
- 17 Bird D, Lambert D, Hartley D. et al. Rural models for integrating primary care and mental health services. *Adm Policy Ment Health* 1998;25(3):287-308.
- 18 New Freedom Commission on Mental Health, *Achieving the promise: Transforming mental health care in America*. Final Report. Rockville, MD: US DHHS 2003. (DHHS publication no. SMA-03-3832.)
- 19 *Quality through collaboration: The future of rural health care*. Washington, DC: Institute of Medicine. The National Academies Press, 2005.
- 20 Bureau of Primary Health Care. Program Information Notice 2003-03: Opportunities for health centers to expand/improve access to mental health and substance abuse, oral health, pharmacy services and quality management services during fiscal year 2003. Available: <ftp://ftp.hrsa.gov/bphc/docs/2003pins/2003-03qa.pdf>. Accessed June 25, 2005.
- 21 Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice* 1998;1:2-4.
- 22 Lambert D, Gale J. Integrating primary care and mental health: Current practices in rural community health centers. Kansas City, MO: National Rural Health Association. (Forthcoming).