

Linking Primary Care and Rural Psychiatry: Where Have We Been and Where Are We Going?

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Linking primary care with psychiatric care has long been promoted as a way to improve access to rural mental health services. The authors describe a national survey that identified 53 successfully linked programs, ranging from small local efforts to sophisticated multicounty networks. Findings indicated that lessons from successful integrations are not easily reduced to a how-to list. Organizations cooperate with each other when it is in their interests to do so. Motivation to integrate cannot be mandated, nor is the availability of funding alone sufficient to provide motivation. The authors discuss ways that managed care may facilitate or hinder the link between rural primary care and rural psychiatry. (*Psychiatric Services* 49:965–967, 1998)

In April 1997 Montana began a mental health managed care plan for the state's Medicaid population. The plan did not include primary care physicians in its provider panel. In the state's 24 counties, persons without a mental health provider soon experienced serious problems in gaining access to mental health

care (1), because primary care is the de facto mental health system in rural areas.

Montana's early stumble with managed care raises a new concern about an old issue: how to improve access to mental health care in rural areas. Limited access stems from problems in the availability and acceptability of mental health care (2,3). Generally, few mental health providers, particularly psychiatrists, work in rural areas. Rural persons are often unwilling to seek mental health care from available providers because of the stigma that may result from being identified as a mental health consumer. In general, stigma may be more strongly experienced in rural areas where people know whose vehicle is parked by the mental health center. On the other hand, for persons with serious and persistent mental illness, the close network of relationships in rural areas may provide informal supports outside of the health and mental health care systems.

Travel distance and poor road conditions may further impede rural residents from obtaining the mental health care they need. Older persons constitute a higher percentage of rural than urban populations (2). Older rural residents face an additional barrier because Medicare limits its payment to psychologists and social workers, although many rural facilities are staffed primarily with licensed professional counselors.

This paper examines issues in linking primary care and mental health care in rural areas. Barriers to linkages, successful linked programs, and future trends are described.

Linking primary care and rural psychiatry

Policy makers have promoted linking primary care with mental health care for more than 30 years to improve access to mental health care in rural areas (3). The development of community health centers and community mental health centers in the 1960s spurred interest in creating these links. The federal Linkage Initiative program (1978–1980) funded community and migrant health centers to hire staff to assess and provide counseling to patients and refer them to community mental health centers. Provisions of the Omnibus Budget Reconciliation Act of 1987 and 1989 broadened Medicare and Medicaid reimbursement to include clinical psychologists and clinical social workers practicing in rural health clinics. The 1993–1994 debate on national health care reform renewed interest in integrating primary care and mental health.

Linking primary care and mental health care in rural areas remains difficult. A persisting problem is failure to appreciate that primary care and mental health providers differ in terms of their patients, reimbursement, and treatment philosophy. Mental health and primary care often continue to view each other from afar, rather than sharing common ground. From the perspective of psychiatry, primary care providers often fail to detect mental illness or they do not adequately treat it (4,5). From the perspective of rural primary care, providers are able to detect mental disorders but often do not diagnose them, either to protect patient confi-

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dentiality or because there are few specialists with whom to consult (6,7).

Depression is the most prevalent major mental health disorder. Rural persons may be more likely to receive care for depression than for other serious mental health problems because primary care providers are more able to diagnose and treat it compared with other disorders such as schizophrenia and bipolar disorder. Primary care providers may use protocols such as the *Practice Guidelines for Depression in Primary Care* developed by the Agency for Health Care Policy and Research. However, there is broad concern that this potential for treating depression is unrealized.

A substantial literature has examined the failure of primary care physicians to detect depression in their patients. How rural primary care providers deal with depression once they have identified it is not well understood. A recent study addressed this knowledge gap by examining factors related to whether rural primary care providers treat depressed patients or refer them to mental health specialists (8). The study found that the number of depressed patients seen by a primary care provider was not related to total patient volume. Barriers to referral to specialists included long waits for an appointment, limited available services, and patients' unwillingness to use services. A primary care provider's knowledge of depression and attitudes about the importance of treating depression were significantly related to whether the provider was likely to treat or refer patients.

The study also found that the supply of mental health providers was not a significant factor in whether a provider treated or referred a depressed patient. This finding is corroborated by a related study in which Medicaid data were used to examine service use of rural and urban Maine Medicaid beneficiaries with depression (9). That study found that primary care providers do not appear to provide more care for beneficiaries with depression in areas where the supply of mental health providers is low.

Successful models

In 1994 the Maine Rural Health Research Center conducted a national

survey to identify successfully linked primary care and mental health programs in rural areas (3). Fifty-three programs were identified, ranging from the Isabel Community Clinic, a small community health center in South Dakota, to the five-county Laurel Health Systems in Wellsboro, Pennsylvania.

A rural health outreach grant spurred the Isabel Community Clinic's expansion into mental health. The clinic's service region is vast and sparsely populated. The mental health component includes two full-time therapists and a substance abuse counselor. In contrast, the Laurel Health System is a sophisticated rural health network involving corporate affiliation of health and social services providers among five rural counties in north-central Pennsylvania. Organizations include a general acute care hospital, six federally qualified health centers, a senior citizen's housing facility, and a mental health provider that offers inpatient, outpatient, and partial hospitalization services.

A third, midsize, program—the Family Medicine Center in Amarillo, Texas—uses family practice residency sites affiliated with the Texas Tech University Health Services Center to serve the Texas-Oklahoma Panhandle area. A basic tenet is that the rural family physician is often the only clinician available to identify and treat behavioral health problems. Residency training includes a rotation in behavioral health care and ongoing responsibility for providing care in inpatient and community settings.

The authors of the report on the 53 programs cautioned that the lessons from successfully integrated programs are not easily reduced to a how-to list (3). Organizations cooperate with each other when it is in their interests to do so. They must recognize the benefits of integration and perceive that they will gain more by integrating services than they will lose by sharing clients or staff. Integration involves each organization's losing some autonomy. Motivation to integrate cannot be mandated, nor is the availability of funding alone sufficient to provide this motivation.

The future

Rural primary care and mental health providers are likely to continue to seek ways to link their services. The pressures of managed care may accelerate this trend. As federal funding for Medicare and Medicaid tightens, parties interested in pursuing these linkages will need to justify them in terms of access, cost, and quality.

Managed care has the potential to facilitate and to hinder the link between rural primary care and rural psychiatry. Many managed care models call for integrating mental and general health care. However, integration remains largely a goal, not a reality (10). Mental health treatment, and the associated financial risk, is usually carved out from general health care. Most mental health carve-outs are designed to work with panels of mental health providers and to rein in mental health utilization. How will carve-outs work in rural areas, where few mental health providers exist, and the challenge is often to enhance service delivery infrastructure, not to trim it?

Rural primary care remains the de facto mental health system in rural areas. Managed care may constrain the willingness of rural primary care providers to treat mental health problems, because such treatment is relatively time consuming. So far, this effect has not been observed in rural states under Medicaid mental health managed care (10). Managed care is likely to continue to limit the number of psychiatrists that rural agencies may employ and how they use them. Psychiatrists are likely to continue to be in demand for consultation on complex cases and for medication management. Less expensive midlevel mental health providers will be used for direct patient care. The extent to which psychiatrists will continue to be used will be increasingly influenced by whether other providers win approval from organizations credentialing providers. ♦

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