Management of Mental Disorders in Rural Primary Care

A Proposal for Integrated Psychosocial Services

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Mental health facilities and specialized providers are particularly lacking in rural areas. Even when these are available, poverty, negative attitudes toward mental health treatments, and traditional rural values of privacy and autonomy often result in low utilization rates. Consequently, most mental health care in rural America is provided by primary care physicians who are also faced with competing demands, including tensions among limited time and resources, the multiple and complex needs of patients, and economic forces determining reimbursements. We propose that in the best interest of physicians and their patients, fully integrated psychosocial services in rural primary care settings would reduce the burden of time-consuming mental health care, conform to patient preference for immediate on-site care, reduce nonproductive medical care use, and eliminate duplication of effort by physicians and mental health professionals. The treatment model we propose would provide multiple arenas for psychosocial intervention — with the individual, the family, and the community — based on the patient's self-identified needs. The integration of psychosocial services within primary rural care is readily available, economically feasible, and urgently needed, but physicians must take the lead to implement this collaborative treatment partnership.

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Eleven million Americans and their families bear the emotional and financial pain of depression,[1] the most prevalent mental health disorder affecting the general population. Many of them are affected chronically, and the sequelae of depression — suicide, addiction, and emotional turmoil — continue to plague family members for generations. The greatest need for help may be in rural America, where patients have rates of major depression equal to or higher than their counterparts in metropolitan areas[2-4] and are as many as 9 times more likely to be hospitalized.[5,6] Unfortunately, many of those suffering from major depression do not receive treatment, even as pharmacologic and psychologic interventions are proving to be efficacious.[7-10]

Mental health facilities and specialized providers are particularly scarce in rural areas. Even when they are available, poverty, negative attitudes toward mental health treatments, and traditional rural values of privacy and autonomy result in low utilization rates.[2,11,12] Rural primary care patients overwhelmingly prefer that mental health treatment be provided in the primary care setting.[13-15] Not surprisingly then, the greater part of mental health care in rural America is provided by primary care physicians who confront the complex task of weighing the social, psychological, and biological factors influencing their patients' requests for medical help.

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CHALLENGES TO MENTAL HEALTH CARE IN RURAL COMMUNITIES

DIAGNOSIS

There are few greater challenges in rural primary care than the detection, diagnosis, and treatment of depression and related mood disorders. Poorly defined symptoms, diffuse somatic complaints, subthreshold symptoms, and high medical comorbidity may confound diagnosis. Primary care physicians' severe time constraints fuel a well-documented and disturbing practice paradox: More than one half of all people suffering from mental disorders seek help through primary care, yet the majority of their conditions — from 50% to 80% — are not diagnosed or are misdiagnosed, and therefore these patients are not treated for their disorders.[16,17] Some of these unrecognized cases may not fit traditional diagnostic criteria, and the patients may not benefit from disorder-level treatments.[18] However, patients who suffer from major depression, a disorder for which the diagnostic criteria are applicable, unquestionably need attention and care. It is especially distressing that more than two thirds of the rural patients treated for

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depression in primary care still meet criteria for major depression 5 months later.[2,19]

Treatment

Accurate diagnosis of depression is only one part of the challenge faced by rural primary care physicians. After a diagnosis is made, significant questions still remain as to who will treat the patient for this disease, what treatment will be offered, and where that treatment will take place. Referral to specialty mental health services is one option for overburdened physicians, particularly those more comfortable with treating the biomedical aspects of disease than the psychosocial ones. Rural patients can be particularly resistant to referral,[12] however, and their physicians have reported that the effectiveness of referral to specialty care is frequently unsatisfactory because of the few referral sources in rural areas,[11] the resulting long waiting lists, and inadequate follow-up.[12] Consequently, from 30% to 74% of patients refuse to follow through when referral is suggested.[20-23] Many rural communities, moreover, are so removed from mental health clinics and mental health specialists that referral is not even an option.

Patient Perceptions

In addition to these structural barriers, mental health treatment of rural patients is especially difficult. These patients often do not recognize their problems as psychiatric,[12,24,25] and they do not want treatment that focuses on psychiatric symptoms.[24,26,27] Rural residents do not usually recognize the "mind-body" split, but rather intuitively integrate mental health, social health, and physical health,[28] which is precisely why they prefer to obtain their care in the primary care setting. In addition, many rural residents often will not seek or use mental health services because of the lack of anonymity in treatment, the stigma associated with treatment, and the value they often place on independence and privacy.[2,11,12,15,29,30] In rural primary care, physicians are especially challenged to provide medical treatment within the press of competing demands, including tensions among limited time and resources, the multiple and complex needs of patients, and a formidable combination of government policies and economic forces determining insurance regulations and fee reimbursements.[18,31] Other primary care practice personnel, such as nurses and physician assistants, infrequently have the necessary training to diagnose and treat mental disorders, and almost never have the time to routinely carry out mental health care. It is unlikely, furthermore, that this situation will change in the future.

BACKGROUND OF PSYCHOSOCIAL SERVICES IN RURAL PRIMARY CARE

Many persons concerned with the delivery of health care services have encouraged a change in our current system to increase the likelihood of responsibly meeting the critical mental health needs of rural primary care patients.[32-34] Several models have been proposed, but few have been tested. For example, formal linkages between rural health and mental health professionals in the United States were attempted on a small scale in the 1970s, when community mental health workers were assigned to primary care practices, usually for 1 half-day per week.[35-38] Although linkage did show early promise,[39] the model was abandoned in the early 1980s with the advent of block grant funding,[23] and formal outcome evaluations were not carried out. However, one of the authors (L.W.B.) has personal experience that linkage was frequently unacceptable to rural patients because of the association of the linkage worker with the mental health clinic. Other exploratory collaborative arrangements have ranged from simple referral agreements to fully integrated health/mental health teams working together on-site. The potential significance of these efforts for rural practice, however, awaits empirical scrutiny. In metropolitan and group primary care settings, several primary care trials of co-located collaborative care are currently underway and show great promise.[40,41] In smaller and more isolated rural practices, however, these models are neither practical nor affordable. Consequently, they are unlikely to emerge as a solution to rural mental health needs in the future.

One recommendation being proposed with increasing frequency is that every family physician have a staff member trained to provide psychological treatment.[9,23,35,36,42-46] This innovation moves in the right direction, but any approach failing to accommodate both patients' preferences for care and their environmental challenges is unlikely to succeed. Physicians report, for example, that depressed patients in primary care tend to have multiple psychosocial and environmental service needs, such as counseling, education, financial assistance, help with life transitions, and other concrete services.[47] Psychological treatment alone, particularly treatment experienced as "psychiatric," does not provide an acceptable goodness of fit with many rural patients and their problem definitions. In a study of 600 low-income and minority patients with mental disorders, for example, 15 categories of requests for treatment were generated from patient interviews, and none was related to psychiatric symptomatology.[26,27] Nearly all requests focused instead on getting help in solving life problems. Identifying "problems in living," a broader concept than psychiatric diagnosis, is apt to appeal more to rural patients and physicians alike. A treatment strategy employing a psychosocial orientation, therefore, is more likely to match the framework for help that physicians and patients in rural settings prefer.

INTEGRATED SERVICES

We propose that psychosocial services be fully integrated within the primary care practice setting to enhance the treatment of rural patients with mental health disorders. This type of integration is in the best interest of physicians and their patients. Access to critically needed treatment is

improved, patient preference for immediate on-site care is provided, psychiatric labeling and social stigma are reduced, and the burden of time-consuming mental health care is lifted from the physician. A broad psychosocial approach, embracing environmental as well as intrapsychic sources of patient distress, best matches the kinds of life problems found among rural patients with mental health disorders, such as depression.

On-site provision of integrated psychosocial services within the primary care practice also removes barriers to treatment access. Patients can be seen quickly, and their psychosocial needs can be addressed by someone who is viewed as a primary care employee, eliminating the stigma of outside mental health consultation. (These advantages will only be realized, however, if sufficient services with per practice flexibility are made available to meet the demand.) Cognitive psychological therapies that focus on life problems and employ problem-solving strategies can be seamlessly infused into a classic case management model recognizing environmental and psychosocial needs of patients. Psychosocial providers can therefore act to mobilize personal, interpersonal, and community resources as they maintain a life problem framework that is more acceptable to these patients than psychiatric referral. The integration of psychosocial services into primary care also permits greater opportunity for exploration of comorbid syndromes and psychological disorders that might otherwise be overlooked in the fast-paced culture of primary care.

ADVANTAGES OF INTEGRATION

In a survey conducted by Badger and colleagues,[47] primary care physicians from the rural southeastern United States reported strong support for the integration of psychosocial services into their practices and endorsed a vast array of case management services as potentially useful. In a series of focus groups held in 1997 and 1998, a more geographically diverse group of more than 50 rural primary care physician members of the Ambulatory Sentinel Primary Care Network felt that fully integrated psychosocial services would be far more acceptable and beneficial to both patients and physicians than most existing systems of collaboration or referral. They strongly supported a model of integrated services that included a partnership between the physician and the psychosocial care provider, who they felt should be a full-time employee of the practice with shared participation in the treatment protocol, medical record keeping, and responsibility for comprehensive patient care.

We suggest that integration of services into the primary care setting encourages interaction between professionals and enhances confidentiality and access for patients. We have little doubt that it will reduce nonproductive medical care utilization and eliminate duplication of effort by physicians and mental health professionals. We believe that social workers are especially suited to provide these psychosocial services because of their similar professional orientation to primary care's emphasis on continuity of care and comprehensive health/mental health care. Although other health/mental health professionals are unquestionably qualified to provide psychosocial services, it is no small advantage that social workers also cost less than psychiatrists or psychologists and are already extensively located in rural areas.[48] Social work has devoted considerable attention to training practitioners for rural mental health practice since the 1970s and currently plays a greater role in rural mental health hospital practice than any other mental health discipline.[49]

A PROPOSED MODEL

We propose a collaborative care model for integrating psychosocial services into rural primary care that has 3 essential features: (1) full on-site collaboration between physician and psychosocial care provider; (2) a psychosocial orientation to mental health assessment and treatment; and (3) a case-management model for psychosocial service delivery. These 3 components ensure that mental health services can be shaped to match the ecological context of rural primary care, patient preference for on-site treatment, physician time constraints, frequent negative rural attitudes toward psychiatric referral, concerns about privacy, symptom presentation focused on problems of living, and sparse community resources.

FULL ON-SITE COLLABORATION

Successful integration of psychosocial services into primary care will require that the physician and psychosocial care provider establish a collaborative working partnership. Each physician/psychosocial care provider team will inevitably create its own style of partnership, according to the personality attributes of each professional and the particular structure and culture of the practice setting. This entails clearly defining (and redefining as the collaboration matures) treatment roles and areas of expertise while developing a unified team approach requiring open communication and coordination of treatment. For instance, some physicians will prefer to determine which of their patients are suitable for psychosocial treatment, while others may augment identification with mental health screening tools or provide for patient self-referral. We envision that the physician and the psychosocial care provider will need to consult each other during office hours. Spontaneous consultation can only occur, however, when both professionals work together on-site and are afforded the opportunity to develop the kind of complementary partnership that emerges naturally through close daily contact. Full collaboration between the psychosocial care provider and the physician also requires some investment of time in reviewing treatment together. The physician and the psychosocial care provider, therefore, would be expected to schedule regular meetings, and hold additional meetings as required, to discuss those patients whose

cases are the most difficult. We recommend, in addition, that the psychosocial care provider write brief notes in patients' medical records, compatible with the format used in the practice and sensitive to its setting. To assure patient confidentiality, more extensive progress notes could be filed separately and made available only to the physician and the psychosocial care provider.

Psychosocial Orientation

The mental health professional who collaborates with the rural primary care physician must be proficient both in diagnosing mental disorders and in psychosocial assessment and intervention. This specialist's training must therefore include not only the standard classification of mental disorders, but also the more broadly defined psychosocial and ecological assessments that would identify those patients with major depression, for example, and also those patients whose subthreshold problems have psychosocial origins. A psychosocial orientation to mental health needs is essential to effectively treat rural primary care patients who typically present with multiple somatic complaints and problems in living. It best matches the patient's own frame of reference and perception of need — more than half the battle in engaging rural patients in mental health treatment.[31] The psychosocial orientation, in general, is less stigmatizing and more comprehensive in scope than specialized psychiatric care.

Case Management Model of Service Delivery

Case management — the "cornerstone in the delivery of contemporary human services"[50] and "the dominant mode for serving the most vulnerable populations"[51] — is an unusually flexible and successful model of service delivery, particularly where services are scarce and poorly integrated within a community.[51-54] Case management provides for continuous boundary-spanning activities that create a better goodness of fit between people and their social environments. Problem-solving activities are pursued by both the patient and the psychosocial care provider outside their sessions, and may involve advocacy efforts to acquire public benefits, such as supplemental security income; Medicare and Medicaid; Women, Infants, and Children (WIC) supplements; or food stamps. Within this model of treatment, the psychosocial care provider can offer patients brief and effective psychological counseling, such as problem-solving treatment,[9,55] as well as psychoeducational intervention, family treatment, and crisis intervention. For treatment of rural patients with depression, in particular, we recommend pairing psychosocial case management with brief models of problem-solving and task-oriented interventions empirically proven effective.[9,55-57] This treatment model provides multiple arenas for psychosocial intervention — with the individual, the family, and the community — based on the patient's self-identified needs, and combines psychological counseling with the acquisition of social supports that many rural residents lack.

Financing a Mental Health Partner

How can a rural physician pay for the mental health professional? There are several possible options that could be used alone or, more likely, in combination. The particular approach will depend on the community, its support for a mental health professional, and the patient demographics of the primary care setting. One possibility is direct billing, but this option is not likely to be sufficient by itself because rural per capita income tends to be very low, many patients are not insured, and carve-outs have reached into rural areas. If the physician could convince the community that it has a stake in a mental health professional, supplemental community funding could be created through a line in the county or city budget. This approach has been attempted with preliminary success in at least one rural community. The paradoxical outcome was that the mental health professional's extensive involvement in the community, in the schools, in family violence prevention projects, and so forth, resulted in her being less available to the clinic itself. A third option might be to establish a collaborative partnership in which the mental health purveyors with the state carve-out agree to place mental health providers in the primary care clinic. Some physicians might value the contributions of a mental health provider so highly that they would designate a portion of their own salaries to provide a direct subsidy. Finally, the primary care physician could hire an intern. Although the limited duration of placement (generally 1 year) might interfere with the desired continuity of services, interns are inexpensive (or free), and their supervision can be provided by the academic sponsor. This option would be very attractive to many social work graduate schools, especially those that place an emphasis on training for rural practice.

CONCLUSIONS

We agree with deGruy[18] that "most rural mental health care will be rendered in the primary care setting or it will not be rendered at all." The model of integrated services that we propose conforms to the recent Institute of Medicine definition of primary care as the provision of integrated, comprehensive, and coordinated services by an individual or a team of professionals.[58] The integration of psychosocial services within rural primary care is readily available, economically feasible, and urgently needed, but physicians must take the lead to implement this collaborative treatment partnership, if it is to become a reality for the millions of Americans who, undetected and untreated, continue to suffer mental distress.

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