Need for Mental Health Services in Federally Funded Rural Primary Health Care Systems

A review of Rural Health Initiative-Health Underserved Rural Area Projects and their relationships with community mental health centers

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ACCESS TO HEALTH CARE and maldistribution of health personnel are current public and private concerns. The expansion of the National Health Service Corps (Public Law 94–484) will help to bring additional physicians and allied health personnel to underserved areas. Also underway are the Rural Health Initiative (RHI) and Health Underserved Rural Area (HURA) programs to help communities establish primary health care systems (*1*). HURA is a research and development program for expanding existing health care delivery capacity in medically underserved rural areas. The RHI is a community based program for developing access to primary care in rural areas that have no current capacity to do so. (The RHI is funded under Section 330, Title III of the Public Health Service Act, which provides funds for community health centers, and HURA grants are authorized by Section 1110, Title XIX of the Social Security Act. Additional funds and support sources for RHI-HURA projects include the Appalachian Health Programs, Migrant Health Program, Emergency Medical Services Program, Community Mental Health Center Program, Drug Abuse Program, and programs of the National Institute of Alcohol Abuse and Alcoholism.)

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RHI-HURA Projects

RHI and HURA provide startup funds, up to $200,000 a year for 3 years, to a nonprofit applicant agency or group. (RHI funding may extend beyond 3 years for effective projects in very poor areas.) The purpose of the funding is to establish a primary (ambulatory) health care system that will become as financially self-supporting as possible and that coordinates existing health resources in a specified catchment area to provide 24-hour coverage for diagnosis and treatment of uncomplicated illness, pre-

ventive and casefinding services, minor surgery, emergency care not requiring specialized personnel and equipment, preventive dentistry, and the Early and Periodic Screening, Diagnosis, and Treatment Program for children.

Also required are appropriate supplemental health services necessary for adequate support of primary health care services such as mental health, alcohol and drug abuse services, transportation, and outreach. Applicants are expected to coordinate or link their activities with health and social agencies and programs in the area, as well as with private health groups including solo and group medical practices. Arrangements must be made for linkages and referral channels to providers of secondary care (inpatient or diagnostic) and tertiary care (highly specialized facilities). The linkages are required to promote access to appropriate levels and types of care and to develop "health care systems."

In 1975, the first year, 47 RHI and 9 HURA projects were funded at a cost of $10.6 million; in 1976, 138 RHI and 53 HURA projects were funded at a cost of $27.2 million; and in 1977, 260 RHI and 88 HURA projects were funded at a cost of $40.1 million. The estimated figures for fiscal year 1978 are 330 RHI and 108 HURA projects funded at a cost of $46 million.

Approved applications were available for review for 160 of the 191 projects funded in 1976, and they were reviewed by Ozarin. The following information was abstracted from these applications: recognition of mental health implications of health care; proposed plans to use or link with mental health, drug, and alcohol treatment resources; current use or sharing of such resources in the community; positions budgeted for mental health-related personnel; proposed or actual contracts with mental health-related providers; and letters of support from mental health-related facilities.

As shown in the table, three-fourths of the applicants recognized mental health needs in the projected patient population, but one-fourth expressed little or no such recognition in their applications. One-third of the applicants were planning linkages with mental health resources, and a number of these linkages applied only to alcohol and drug services; almost a third of the applicants were currently using or sharing such services. Only 6 percent had actually contracted for mental health services or planned to do so, and 15 percent had budgeted positions for mental health-related personnel—usually social workers.

Relationships with community mental health centers. The RHI-HURA grants were matched with the catchment areas of federally funded community mental health centers (CMHCs). Nationwide, 64 percent of the catchment areas overlapped in one or more counties—ranging from a high of 92 percent in DHEW Region I (New England) to a low of 14 percent in DHEW Region II (New York, Pennsylvania, and Puerto Rico).

Earlier, the 56 RHI-HURA programs funded in fiscal year 1975 were matched with CMHCs, and it was found that 20 overlapped in 1 on more counties. Telephone calls were made to each of the 20 CMHCs to obtain information on the nature and extent of relationships between programs. Three CMHCs had

Mental health-related information abstracted from 160 approved 1976 grant applications for Rural Health Initiative (RHI) and Health Underserved Rural Area (HURA) projects

Mental health-related information [1]	*RHI grants*	*HURA grants*	*Total*	
			Number	*Percent*
Recognition of mental health need	113	44	157	98
None or little	28	8	36	23
Moderate	32	15	47	29
Great	53	21	74	46
Planning linkages with mental health resources	42	17	59	37
Currently using or sharing community resources	35	15	50	31
Positions budgeted for mental health-related personnel [2]	19	6	25	15
RHI and HURA contracts for mental health services	8	2	10	6
Letters of support from mental health agencies	14	9	23	14

[1] Applications mentioning alcohol and drug concerns were included with mental health information.

[2] Most of these positions were for social workers.

NOTE: Totals do not add to 160, the number of applications reviewed, because information was not complete in each application.

no relationship with the RHI. In 4 instances, the RHIs had contracted with the CMHCs for mental health services, and 17 CMHCs had a variety of relationships, including the following:

- The CMHC satellite and the health center facilities were adjacent.
- Much informal contact and referrals took place.
- The CMHC provided inservice training for health center staff.
- Health center physicians provided backup for mental health workers.
- The health center and the CMHC shared the same building (but the health center was being moved to its own facilities).
- Graduate nursing students were working in both programs.
- A CMHC psychiatrist provided consultation to a health center physician.
- Both staffs had cooperative relationships.
- CMHC staff visited health center outposts regularly.
- Both staffs referred patients to each other.
- CMHC staff provided consultation to health staff.
- Health center in one location had contracted for CMHC consultation.

The following example illustrates RHI-CMHC collaboration. Two rural counties (population 9,000; 50,000 square miles) in the northwest had a RHI grant that permitted stationing two nurse practitioners; they were supervised by two National Health Service Corps physicians located more than 50 miles away. The CMHC covering these counties had stationed a psychiatric nurse in a satellite 65 miles from the center base. This nurse was a board member of the RHI. The three nurses shared emergency work and covered for each other; they referred patients to one another, and often they saw the same patients and families. Their working relationship was described as "strong."

RHI-HURA grantees included general hospitals, health and welfare departments, university health centers and medical schools, group private practices, and consumer or community groups. One federally funded mental health center is also a grantee. (CMHCs in rural areas are providing community services other than mental health, such as home health services, speech and hearing services, and nutrition services.)

A relationship between sponsorship and recognition of need for mental health services was not always discerned. For instance, a Citizens County Action Corporation in the northeast, which started as an OEO project and went on to provide a wide range of health and welfare services, contracted with the local CMHC for speech and hearing services, mental health consultation, inservice training for staff, and direct patient care. In contrast, a large general hospital in the same State received a grant for a pediatric project to use nurse practitioners supervised by a pediatrician and also provide services of a child psychiatrist. However, this project had no communication with the local CMHC (which had more than 50 employees in a home health service), employed no social workers, and had no plans to do so.

Another grantee is a town government in the deep South. This town has a population of 1,700. More than half of the people are at the poverty level, and 70 percent are black. The town plans to establish an outreach satellite clinic from the nearby CMHC.

A project in West Virginia, sponsored by a county health council in a county with 27 percent of the population at poverty level, provides health care for chronic psychiatric patients who had been in State hospitals. The CMHC in the area provides social services for the RHI.

An eastern medical school received a grant for a pediatric project and budgeted for six social workers and aides but did not mention mental health services in its application. Another eastern medical school grantee noted that negotiations were underway to move the existing mental health service into a new ambulatory health care facility.

Several applications described in great detail concerns relating to mental health. An application from an Appalachian hospital noted that depression and hopelessness, situational neuroses, and alcohol abuse were widespread among the population it serves. A hospital grantee in a burgeoning Alaska town stated that current health services were fragmented, and that violent behavior, accidents, alcoholism, and family problems were common. This hospital was budgeting funds to integrate mental health services into the primary health care system.

Staffing. Recruitment and retention of professional personnel in rural areas has been difficult. Building a health care system, as exemplified by RHI-HURA, has been showing potential for improving the supply of health care personnel. Many applicants have recruited National Health Service Corps physicians and nurses or planned to do so if the site met the eligibility requirements. They expected that these

personnel would remain in the community after the grant expired because conditions for practice would become more attractive. (The conditions of the grant require linkages to be established with secondary and tertiary health care providers and a sound fiscal plan to be established by use of all third-party payer resources. Provisions for continuing education are reimbursable from the grant.)

A large budget item in most grants is health care staff. Some applicants contract with local solo or group medical practices to provide services, and many have recruited National Health Service Corps personnel. Teaching facilities use family practice residents. Most applicants plan to use nurse practitioners, especially in satellite locations, and a small number budget for physician's assistants. Ready telephone communication to backup physicians is available, and a few sites are experimenting with slow-scan television communication.

Social workers were mentioned in 15 applications. Although the applications did not describe the roles of these workers, there seemed to be acceptance of the need for attention to social conditions and problems, especially for poverty-level and migrant populations. Psychologists were included in four applications, psychiatrists in two, and mental health coordinators in three. A western grantee budgeted for a director of a local mental health clinic and a consultant psychiatrist; the clinic was to be transferred from State to local control. One grantee wrote "psychiatrists are too expensive for average low income population" and proposed to add a social worker.

Mental Health Implications

The mental health implications for delivery of ambulatory health care have been documented by Shepherd and associates (*2,3*). In a study of a group of general practices in London, they found that of 15,000 patients at risk in a 12-month period (1961–62), 4 percent consulted a physician at least once for a condition diagnosed entirely or largely to be psychiatric—most were diagnosed as psychoneuroses or personality disorders. No more than 1 in 20 of these patients had been referred to mental health facilities. Although emotional disorders were found to be associated with a high demand for medical care, most of the physicians who treated these patients did not attempt psychotherapy. One-fourth of the patients received counseling.

In a similar study in Monroe County (New York), it was found that 17 percent of general practice patients had psychiatric disorders (*4*). In another study in the same area, patients of five general medical outpatient clinics (two were university based) in four hospitals were surveyed (*5*). Of 1,413 patients 15 years or older, 22 percent who came for physical reasons were judged by their clinic physicians to have emotional disorders. Of all patients considered to have a primary psychiatric diagnosis, 14 percent were judged to have psychoses, 44 percent neuroses, and 28 percent personality disorders. The medical clinics provided therapy for 94 percent of those with neuroses, 85 percent of those with personality disorders, and about 66 percent of those with psychoses.

Goldberg and associates (*6*) reported that when a short-term outpatient psychiatric benefit was added to a prepaid group health plan and appropriate patients were identified and referred for this benefit, the study patients made approximately 30 percent fewer outpatient medical visits and had 30 percent fewer laboratory procedures during the year after referral than in the previous year.

Regier and Goldberg (*7*) reported the results of the first annual national probability sample survey of ambulatory medical care visits to office-based physicians of all major specialties. The survey was carried out by the National Center for Health Statistics in 1973. A striking finding was that mental disorders were diagnosed in 5.4 percent of all the visits made by adults to family and general practitioners, internists, pediatricians, and obstetrician-gynecologists. Moreover, 46 percent of all visits made by patients with a principal diagnosis of mental disorder and more than 58 percent of visits made by patients with any diagnosis of mental disorder, principal or otherwise, were to physicians other than psychiatrists. Nonpsychiatric physicians used psychotherapy and listening in 22 percent of the visits by patients with a principal diagnosis of mental disorder, drug therapy in 67 percent, and medical counseling and advice in 32 percent.

Discussion

Studies cited earlier (*2–6*) point out that general health practitioners are encountering and treating considerable numbers of persons who have primary or secondary mental disorders. The RHI-HURA applications showed that, although there is increasing recognition of this situation, not all grantees are attempting to provide mental health services.

The extensive use of nurse practitioners and other health care personnel who function relatively independently, but under medical supervision, draws attention to the preparation of such personnel to recognize and deal with mental disorders. Reid (*8*) reported that mid-level health professionals can func-

tion successfully under defined conditions. They often operate under written protocols. The role of psychiatrists and mental health-related professionals in the preparation of health care personnel who are practicing relatively independently may need both exploration and emphasis. Consideration should be given to expanded use of consultation by mental health professionals with general physicians and other health care staff.

A number of effective approaches to provision of mental health services have been reported. Stationing mental health personnel in or near health centers seems to bring services closer together. Borus (*9*) studied 19 neighborhood health centers in Boston. These centers had evolved specific linkages between health centers and mental health care providers. He proposed that "mental health services provided in primary care settings are highly accessible and acceptable, benefit from early case findings, successful referral and coordination with general health services, and add to the efficiency of the primary health care system."

Coleman and Patrick pointed out that patients seeking help in a primary care setting do not necessarily regard themselves as suffering from a psychiatric condition (*10*). Their study of the Community Health Center Plan of New Haven with 17,000 enrollees showed that 8 percent of all visits were for emotional problems; 54 percent of all visits of patients with emotional problems were to primary care clinicians, and 43 percent were to mental health clinicians. They stated that "The primary care clinician can often treat the depressed, the somatizer, the highly anxious without necessarily labeling or confronting the patient who fears or avoids psychiatric referral." Coleman and Patrick recommended that primary care clinicians be trained regarding emotional illness, that liaison psychiatry should assume a major role in primary care, and that mental health care providers become members of the primary health care team. They added that although long-term psychotherapy is inconsistent with the New Haven model, crisis intervention and early brief treatment and education are possible.

Recurring terms in the pertinent literature are "family dynamics" and "psychosocial aspects of illness." These concepts seem to have become an accepted province for primary health care clinicians and probably constitute the focus for their mental health-related training.

Psychiatrists and other mental health clinicians are primary, secondary, and tertiary care providers. As primary care providers in primary care settings and in collaboration with other primary health care clinicians, their role is to teach, supervise, and, when appropriate, to diagnose and provide short-term treatment. As providers of specialized care, mental health clinicians function as diagnosticians and therapists for persons with more severe or complicated mental disorders—in addition to consultative, supervisory, and teaching roles. Clear differentiation of these roles may help RHI-HURA grantees to integrate mental health services into their primary care systems and allow the benefits of mental health care to be extended to a much wider population.

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Addendum. The Bureau of Community Health Services, Health Services Administration, made $1.5 million available in fiscal year 1978 to establish linkages between federally funded rural and urban community health centers, migrant health centers, and community mental health centers. A contract between the local agencies will provide for stationing a mental health professional in the health centers with linkage and referral channels to the community mental health center. Applications have been approved for 57 projects; two-thirds of the projects are located in rural areas. The program will be evaluated.

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