Research & Policy Brief

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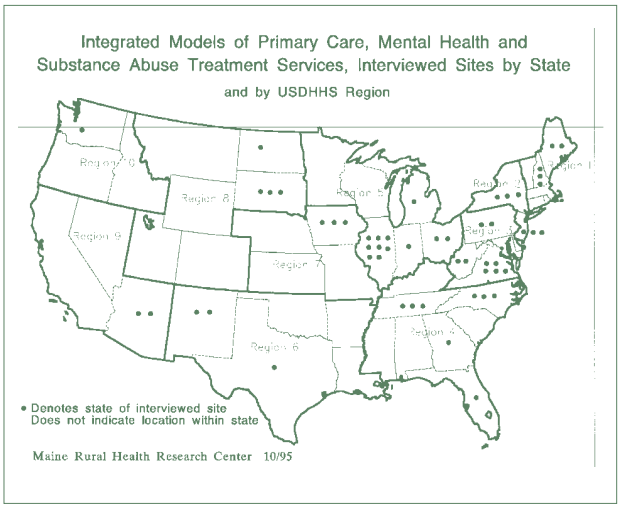
Rural Models for Integrating Primary Care, Mental Health, and Substance Abuse Treatment Services

Policymakers have long championed the integration of mental health and substance abuse treatment services into primary care as a means to improve access, quality, and cost of care. In many rural areas, service integration may be the only option for assuring access to these services. Some areas lack specialty mental health professionals. Physical distance, adverse weather, and lack of public transportation present barriers to care even when resources are available. Many rural residents are unwilling to use these services because of the stigma associated with mental illness and substance abuse and concerns about confidentiality.

This study describes models for integrating mental health and substance abuse treatment services with primary care in U.S. rural communities. Findings are based on a telephone survey of 53 rural primary care providers that successfully linked with mental health and/or substance abuse treatment services. Over half of respondents were community health centers; the rest included hospitals, local health departments, HMOs, and physicians in private practice.

Respondents used four models of integration, usually in combination. *Diversification* involves the primary care organization hiring staff to provide mental health and/or substance abuse treatment services on site. *Linkage* occurs when the primary care organization uses an independent practitioner or an employee of another organization to provide these services on site. *Referral* includes a variety of arrangements to assure that off-site mental health or substance abuse treatment services are available to primary care patients who need them. *Enhancement* emphasizes training primary care practitioners to improve their ability to recognize, diagnose, and treat mental health and substance abuse problems independently.



Although staff availability inhibited the efforts of some respondents to provide mental health or substance abuse treatment services, others had no problems finding qualified staff. Several were approached by mental health providers interested in placing staff at their sites. One addressed the problem of staff availability by using externs from a clinical psychology training program. Another used lay outreach workers.

Most respondents were as likely to treat patients with chronic or severe mental illness directly as they were to refer them to specialty providers. They offered a range of services either directly, by referral, or through a combination of both strategies. Services most likely to be offered directly included individual and family counseling and outreach and community education. Services most likely to be offered by referral only included self-help, detoxification, day treatment, acute hospitalization, and residential care.

Respondents favored informal methods of patient information transfer. Face-to-face and telephone conversations were used most often, although a significant proportion conducted case conferences. A number used fax machines to send information to other providers. Some were prohibited by state law from using common charts for physical and mental health. Respondents assured us that patient information transfer is only done with the patient's written consent.

Primary care practitioners in over 85 percent of responding organizations prescribed psychotropic medications to patients who needed them. Seventy percent of respondents had consultation readily available to assist them in prescribing psychotropic medications. Many had agreements with psychiatrists for telephone consultation, although some experienced delays in receiving needed advice.

Major revenue sources for integrated mental health and substance abuse treatment services included Medicaid, self-payment on a sliding fee basis, and private insurance. One respondent used enhanced Medicaid and Medicare reimbursement resulting from Federally Qualified Health Center (FQHC) certification to hire a full-time licensed clinical social worker. Others noted that Medicaid and Medicare do not reimburse the masters' level counselors who often staff these programs. Organizations serving multiple states observed that cross-state variations in reimbursement policies often affected staffing decisions.

Managed care, Medicaid waivers, and various market-based reforms create incentives for arrangements that place increased emphasis on interorganizational networks. Service integration is fundamental to these approaches. Given persistent and largely unsolvable limitations in the availability of specialty mental health services in rural areas, rural primary care providers are likely to play an expanded role in identifying and treating the mental health and substance abuse problems of their patients.

Donna C. Bird, M.S., M.A., Research Associate
David Lambert, Ph.D., Research Associate
David Hartley, Ph.D., Director, Maine Rural Health Research Center
Peter G. Beeson, Ph.D., Director, Office of Planning, Nebraska Department of Public Institutions
Andrew F. Coburn, Ph.D., Principal Investigator, Maine Rural Health Research Center

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