

Mental Health and Primary Care In Rural Minnesota

Information-At-A-Glance

- ◆ A survey of state and local rural health leaders finds mental health and mental disorders to be the fourth most often identified rural health priority.
 - ◆ The suicide rate among rural males is higher than among their urban counterparts across all four regions of the nation.
 - ◆ Among 1,253 smaller rural counties with population of 2,500 to 20,000, nearly three-fourths of these rural counties lack a psychiatrist, and 95 percent lack a child psychiatrist.
 - ◆ Access to mental health care and concerns for suicide, stress, depression, and anxiety disorders were identified as major rural health concerns among state offices of rural health.
- **Source: Gamm, L.G.; Stone, S.; and Pittman, S. (2003) Mental Health and Mental Disorders – A Rural Challenge. Rural Healthy People 2010: A companion document to Health People 2010. Vol.1. College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.**

Introduction

For consumers, accessing mental health services is not easily done for a variety of reasons. The stigma associated with mental illness, the lack of available information, and a complex health care system are just a few of the obstacles contributing to the difficulty of obtaining mental health services. For rural populations, additional difficulties such as values of individualism and self-reliance compounded by geographic isolation, lack of public transportation and an inadequate supply of medical services often make mental health services even less attainable. In response, advocates and policymakers are calling for reform of the current system of mental health services in the United States to improve access and accountability.¹ Much of this effort is focused on developing a greater public understanding of the connection mental health has to a person's physical health, and the fact that a person's well being is directly connected to the well being of entire communities.

¹ President's New Freedom Commission on Mental Health, Goal 2, recommendation 2.3.

The term “mental health services” is often used to describe a variety of mental health activities. Broad use of the term in this profile will refer to all forms of mental health care including diagnostic, treatment and preventive care that helps improve how a person with mental distress feels both physically and emotionally as well as how he or she interacts with others.

Minnesotans and Mental Health

According to the Mental Health Association of Minnesota, 950,060 Minnesotans have mental health problems of some kind. That is approximately 19 percent of the state’s population. Additionally, 173,249 Minnesotans have a diagnosable “serious” mental illness in any given year.² Some of the more prevalent mental health problems are depression, anxiety, stress, substance abuse, sleep problems, chronic fatigue and unexplained somatic symptoms.

Suicide, a common, measurable indicator for assessing mental health status, ranks as the second leading cause of death in Minnesota for people between the ages of ten and thirty-four.³ Twenty-three percent of ninth grade students in the 2001 Minnesota Student Survey responded that they had “thoughts of suicide” and seven percent responded that they have “tried to kill” themselves in the past year. Suicide rates are significantly high among the elderly in Minnesota as well. In 2000, the suicide rate was highest among people 85 years and older (14.0 per 100,000).⁴

Minnesota is also experiencing a reduction in the number of inpatient psychiatric beds. According to the Minnesota Department of Human Services, the lack of access to inpatient psychiatric beds affects all Minnesotans, “but is especially problematic for children and adolescents due in part to a shortage of inpatient capacity.”⁵

While studies have shown that prevalence of mental health distress in rural communities is no greater than that in urban and suburban areas, there is a greater chance that mental health services may be limited or nonexistent in rural settings. The U.S. Department of Health and Human Services reports that, nationally, the supply of specialty physicians decreases as urbanization decreases. Thus, there is a greater likelihood that mental health problems in rural areas are overlooked and left untreated.

Workforce Shortage

² National Council for Behavioral Health.

³ MDH, Office of Family Health.

⁴ Ibid.

⁵ Minnesota Department of Human Services, Mental Health Division, Continuing Care Adult Mental Health. <http://www.dhs.stae.mn.us/contcare/mentalhealth/default.htm>.

Psychiatry, psychology, social work, psychiatric nursing and marriage and family counseling are often considered the “core” mental health professions. Despite the limitations on workforce data describing these health care professions, shortages exist in rural areas among specific mental health specialties. In Minnesota, there are only 10 psychiatrists per 100,000 population vs. 16 psychiatrists per 100,000 in the U.S.⁶ This is about 33 percent fewer psychiatrists per capita than the national average.⁷ In greater Minnesota, the ratio was 7.3 psychiatrists per 100,000 population in 2002. Physician workforce data also shows that many psychiatrists in Minnesota are working part-time and are not likely to be practicing in non-metro areas. In fact, statistics reveal that 83 percent of psychiatrists in Minnesota practice primarily in an urban area (seven-county metro, Olmsted, Stearns and St. Louis Counties).⁸ Psychiatrists are also aging, like a majority of Minnesota’s rural population. While the average age of a psychiatrist in Minnesota is fifty-one years, in rural areas it is slightly higher.⁹ This indicates that the need for psychiatry services in rural areas is likely to increase given the number of expected retirements among psychiatrists.

Existing workforce data on the remaining core mental health professions, such as psychology and social work, is limited to licensing information collected by the state’s regulatory boards. Data limitations include enumerations for the entire profession rather than for the segment engaging in direct services. The Minnesota Board of Social Work reports a total of 9,199 licensed social workers being listed with a Minnesota mailing address as of 2003. Of these, 5,215 have a mailing address in the seven-county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington), while 3,984 have mailing addresses in greater Minnesota. Statewide, there are approximately 187 social workers per 100,000 population. This translates to approximately 197.4 per 100,000 in the seven county metro region and around 174.9 per 100,000 in greater Minnesota.

The Minnesota Board of Psychology reports 3,288 licensed psychologists practicing in Minnesota as of 2003. This is approximately 66.8 psychologists per 100,000 population, well above the national average of 31.2 per 100,000 population as reported by the U.S. Bureau of Health Professions in 1998. However, the availability of psychologists in greater Minnesota is not as encouraging. Differences in psychologist to population ratios vary widely from zero in 13 non-metro counties to 123.7 per 100,000 in Hennepin County.

The National Health Services Corps has identified psychiatrists, clinical psychologists, psychiatric nurses, clinical social workers, and marriage and family counselors as mental health providers eligible for loan repayment in exchange for service in Mental Health Professional Shortage Areas (MHPSAs). See Map 1. Given that national workforce data on the other mental health professions is inconsistent, MHPSAs are designated solely on the distribution of psychiatrists providing outpatient treatment. Loan assistance programs

⁶ Minnesota Psychiatric Society Taskforce, 2002.

⁷ Ibid.

⁸ MDH Office of Rural Health and Primary Care 2002.

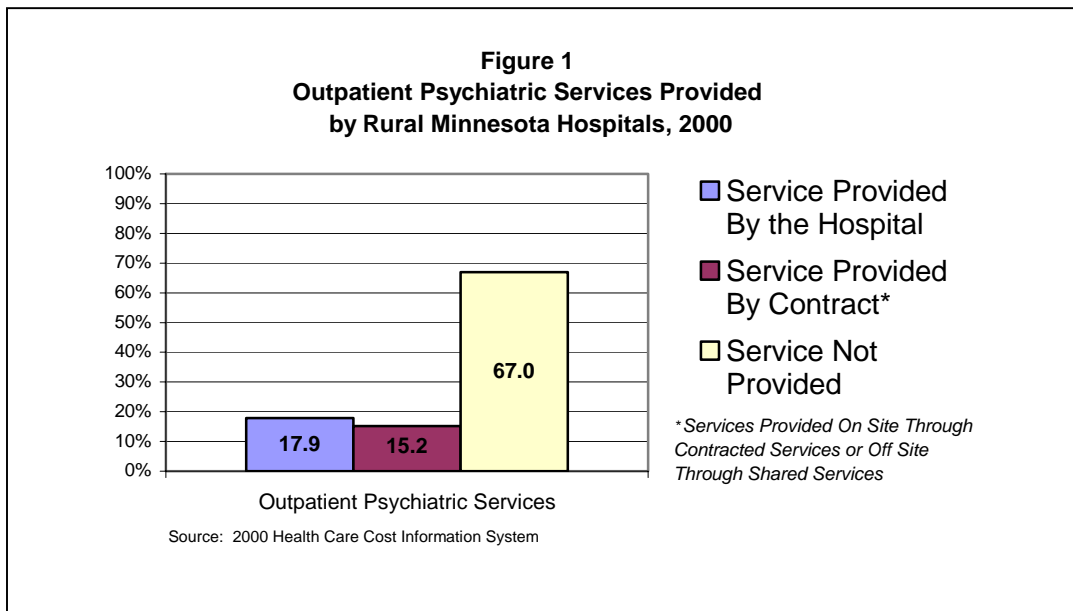
⁹ Ibid.

like the National Health Service Corps are intended to improve the recruitment and retention of mental health professionals to underserved areas.

Outpatient Psychiatric Services

A lack of outpatient psychiatric services, especially crisis services, in rural hospitals can be another indicator of the shortage of mental health professionals in the immediate area. In 2000, only 33.5 percent of Minnesota hospitals reported providing outpatient psychiatric services. An analysis of Minnesota’s rural hospitals reveal that only 20 (18 percent) have outpatient psychiatric services delivered onsite directly by hospital staff, while 17 (15 percent) contract with onsite services or provide services offsite via shared service agreements. See Figure 1.

Patient wait time for a mental health appointment in rural and underserved areas is often three months.¹⁰ Not having timely access to mental health services increases the likelihood that needed care will ultimately occur in an acute care setting. In fact, mental health disorders are the fifth leading cause of hospitalizations in all of Minnesota and the ninth leading cause of emergency room treatment.¹¹



Mental Health Parity

¹⁰ *Minnesota Nurse Practitioner Student Newsletter*, Office of the Collaborative Rural Nurse Practitioner Project; April 2001, vol.7, no 5; p.4.

¹¹ MDH Injury and Violence Prevention Unit, 2001.

Mental health parity means equivalent benefits and restrictions in insurance coverage for mental health services and for other health services. In general, mental health specialists do not receive equitable reimbursement when providing mental health services. The Minnesota Psychiatric Society Taskforce reported that in 2002, psychiatrists were paid 10-40 percent less than primary care physicians for outpatient work. This has much to do with reimbursement policies that favor generalized care over specialty mental health care. Placing mental health services on equal footing with physical health services would improve consumer access to services. For example, health insurance plans restrict mental health benefits by limiting the number of covered visits to a psychiatrist or psychologist. Older consumers are not able to fully access mental health services because Medicare pays only half the cost and places a 190-day lifetime limit on care in a freestanding psychiatric hospital. According to the Minnesota Hospital Association, in 2000 the average cost of treating a psychiatric patient in a hospital was \$1,388 (per day), but health plans paid an average of only \$678.

The Minnesota Psychiatric Society Taskforce reports that the percentage of health care premiums that go to mental health reimbursement dropped 16 percent between 1998-2002, down to 2.6 percent of the premium. As for individuals reliant on Minnesota's safety net programs, Medical Assistance (MA) rates for outpatient psychiatric services are discounted 25 percent from the median charge in 1999, which is not enough to cover expenses.¹²

Role of Public Health

Public health serves a unique role by promoting the early detection of mental health problems. The public health approach maintains that the promotion of good individual mental health leads to healthier populations. In Minnesota, improved mental health is one of twelve public health goals that communities are asked to consider when planning for their communities' health. The application of a public health model is intended to encourage early recognition of mental health problems and appropriate interventions through the coordination of services to ensure a continuum of care. For example, Olmsted County Public Health Services developed a program to serve those with serious mental illness who repeatedly are hospitalized due to medication noncompliance. Practical nurses or public health nurses visit patients' homes regularly, administering prescribed medication and providing reminders about managing their daily living. The nurses also meet monthly with social services to review the condition and progression of each client. These home visits are an example of how health services coordination can help ensure a client's continuity of care with doctors, pharmacies and social services, while making it possible for the client to continue living independently in the community.

Public health prevention measures also are put into practice thanks to community mental health programs. These programs provide an array of behavioral health services, such as outpatient therapy, psychiatry, community support, inpatient and residential therapy. Operated by non-profit organizations or local counties, community mental health

¹² Mental Health Association of Minnesota.

programs provide a majority of the non-hospital/non-residential services in Minnesota.¹³ Their boards of directors are community-based to enhance regional accountability. They also serve as an important safety-net provider of mental health services by providing therapy on a sliding fee scale. Community mental health centers and their satellite offices exist in approximately 78 locations throughout Minnesota. See Map 2.

Mental Health and Primary Care

Of physicians employed in Minnesota, 43.7 percent report that their first specialty is in primary care.¹⁴ In rural counties, primary care physicians account for 61 percent of the workforce.¹⁵ However, the ratio of primary care physicians to the population is still lower in rural Minnesota than in urban Minnesota. There are only 70 physicians for every 100,000 rural Minnesotans compared to 120 physicians for every 100,000 urban Minnesotans.¹⁶ As a result, primary care physicians practicing in rural areas are seeing and treating a wide range of patients.

Primary care has long been considered as a way of expanding access to mental health services given the scarcity of mental health specialists in rural areas. Research has shown that rural physicians already tend to play a greater role in mental health care provision than their urban counterparts. In fact, primary care has been referred to as the “de facto mental health system in rural areas.”¹⁷ A 1999 survey of rural primary providers revealed that most thought 10 percent of their patients’ needs were primarily mental health.¹⁸ According to the National Council for Community Behavioral Care (NCCBC), 50 percent of all mental health care is delivered by a primary care provider. NCCBC also found that 92 percent of all elderly patients receive mental health care from a primary care provider. In addition, studies show that rural patients prefer and are more likely to discuss psychological concerns with their primary care physician given their worries about confidentiality and reservations about consulting specialists.

However, there are some practical issues that challenge the idea that

Additional Facts About Primary Care and Mental Health:

- ◆ Individuals with psychological disorders visit their primary care physician twice as often as individuals without psychological disorders. (Michigan Psychological Association)
- ◆ The most common mental health disorders treated by rural primary care practitioners in one study included depression, anxiety and panic disorders, attention deficit disorder and dementia among the elderly. (Journal of Rural Health)
- ◆ The American Psychological Association reports that 50 to 70 percent of usual visits to primary care are for medical complaints that stem from psychological care.

¹³ Minnesota Association of Community Mental Health Programs (MACMHP)

¹⁴ Minnesota Physician Workforce Profile 2001, MDH Office of Rural Health and Primary Care.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Lambert, D., Hartley, D., *Linking Primary Care and Rural Psychiatry*,

¹⁸ Geller, J. *Rural Primary Care Providers Perceptions of Their Roles in the Provision of Mental Health Services: Voices from the Plains*, Journal of Rural Health, 1999, vol. 15, no.3, p328.

primary care is the best alternative for expanding mental health services. Primary care physicians in rural areas are already faced with competing demands, including tensions about limited time and resources, growing multiple needs of patients, and economic forces determining reimbursements.¹⁹ While many rural residents seek assistance through their primary care physician for a mental health condition, one study estimated that 50 to 80 percent are not diagnosed or misdiagnosed.²⁰ A survey of rural primary care physicians revealed that many often feel they are not adequately trained to provide a full range of mental health services.²¹ Fewer community resources in rural areas also lead to less support and referral opportunities for primary care physicians to utilize. Additionally, medical literature cites that the relationship among primary care physicians and mental health professionals is often strained; much of this is due to a perceived lack of professional regard for the other's profession.²²

Numerous research studies assert that joining existing mental health services with primary care is beneficial for both rural physicians and consumers. Also, working in concert may be the only way that primary care physicians and mental health professionals can overcome the dynamic that exists between them. Existing integration models range from onsite collaboration by co-locating mental health services in a primary health care clinic to residency training that includes a rotation in behavioral health care. A recent study of issues involved in linking primary care and mental health in rural areas mentions that numerous integration models exist in communities, but integration is only likely when primary care and mental health providers recognize that cooperation is in their interest.²³

Conclusion

Linking mental health services with primary care is being promoted as the “policy ideal” among U.S. policymakers. However, reality for most rural communities is that primary care has become the “de facto” system for delivering mental health services. The role of rural primary providers in mental health care provision is not expected to change any time soon. A shortage of providers in specific health care fields, such as psychiatry, is projected to continue, and the demand for mental health services will likely balloon with our aging baby boom population. Additionally, rural uncertainty about mental health specialists is not likely to change. This is evident from reports showing rural consumers prefer discussing mental health issues with their primary care physician rather than a mental health specialist. Primary care physicians, however, do not feel they have the

¹⁹ Badger, L., Robinson, H., Farley, T.; *Management of Mental Disorders in Rural Primary Care A Proposal for Integrated Psychosocial Services*, The Journal of Family Practice, Aug. 2003.

²⁰ Ibid.

²¹ Geller, J., *Rural Primary Care Providers' Perceptions of Their Roles in the Provision of Mental Health Services: Voices From the Plains*, The Journal of Rural Health, Summer 1999, p. 329.

²² Ibid.

²³ Lambert, D., Hartley, D., *Linking Primary Care and Rural Psychiatry: Where Have We Been and Where Are We Going?*, Maine Rural Health Research Center, Edmund S. Muskie Institute of Public Affairs, Univ. of Southern Maine.

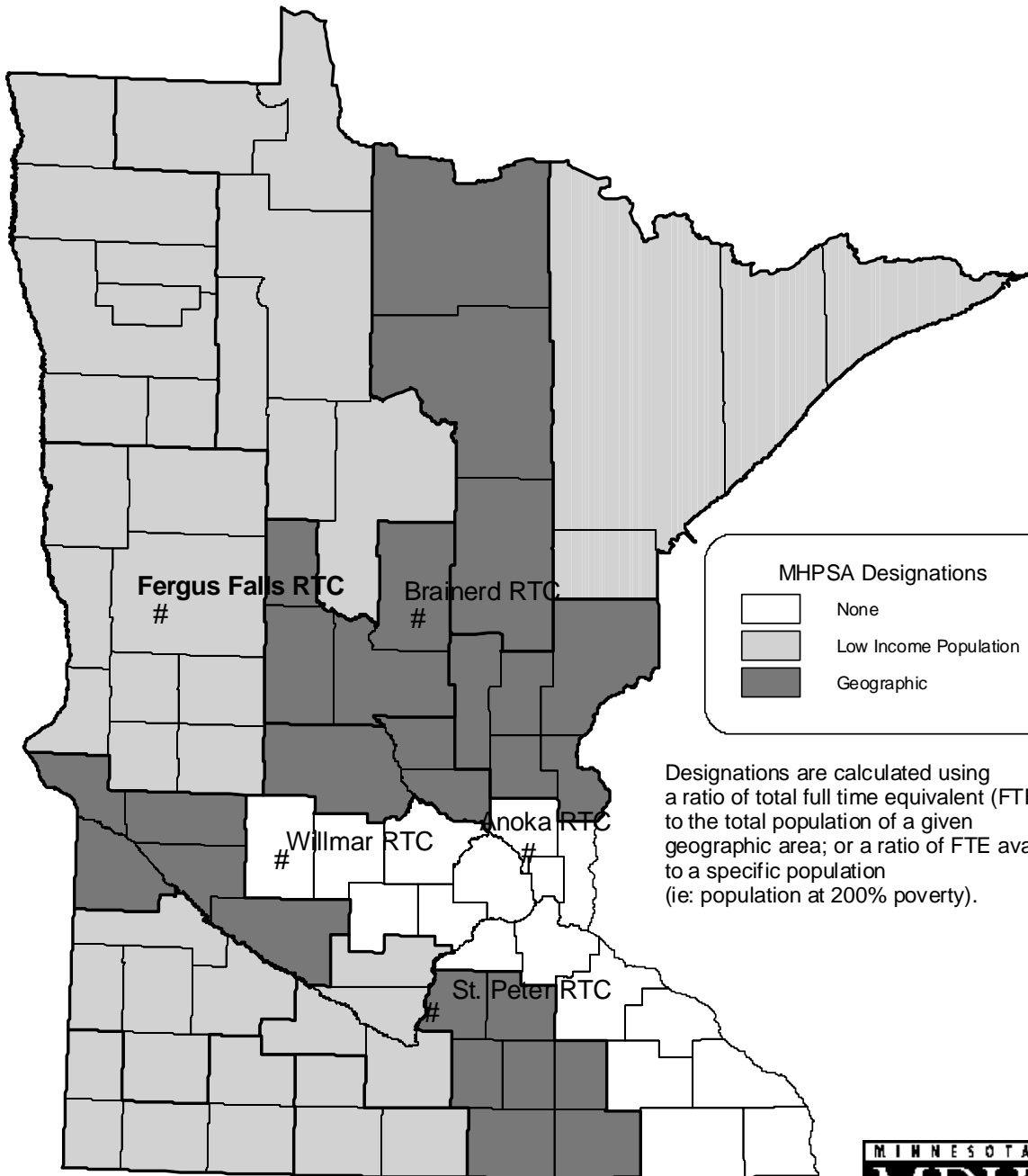
necessary skills or time to detect or thoroughly treat the symptoms of mental distress, and collaboration among the mental health and primary care communities does not always exist. Fostering collaborative relationships among rural health care providers could be the next step to ensuring more equitable mental health care delivery to rural consumers.

The mental health profile was published by the Office of Rural Health and Primary Care in October 2003 and supplements the 2003 series of health profiles focusing the availability and distribution of health care services and providers throughout Greater Minnesota. The profiles highlight the changing demographics, workforce shortages, equitable reimbursement issues, and other challenges unique to hospitals, clinics, nursing homes, ambulance services, and pharmacies operating in rural Minnesota. Copies of profiles are available at <http://www.health.state.mn.us/divs/chs/rhpc.htm>



**Map 1
Health Professional Shortage Areas
September 2003**

Mental Health Designations



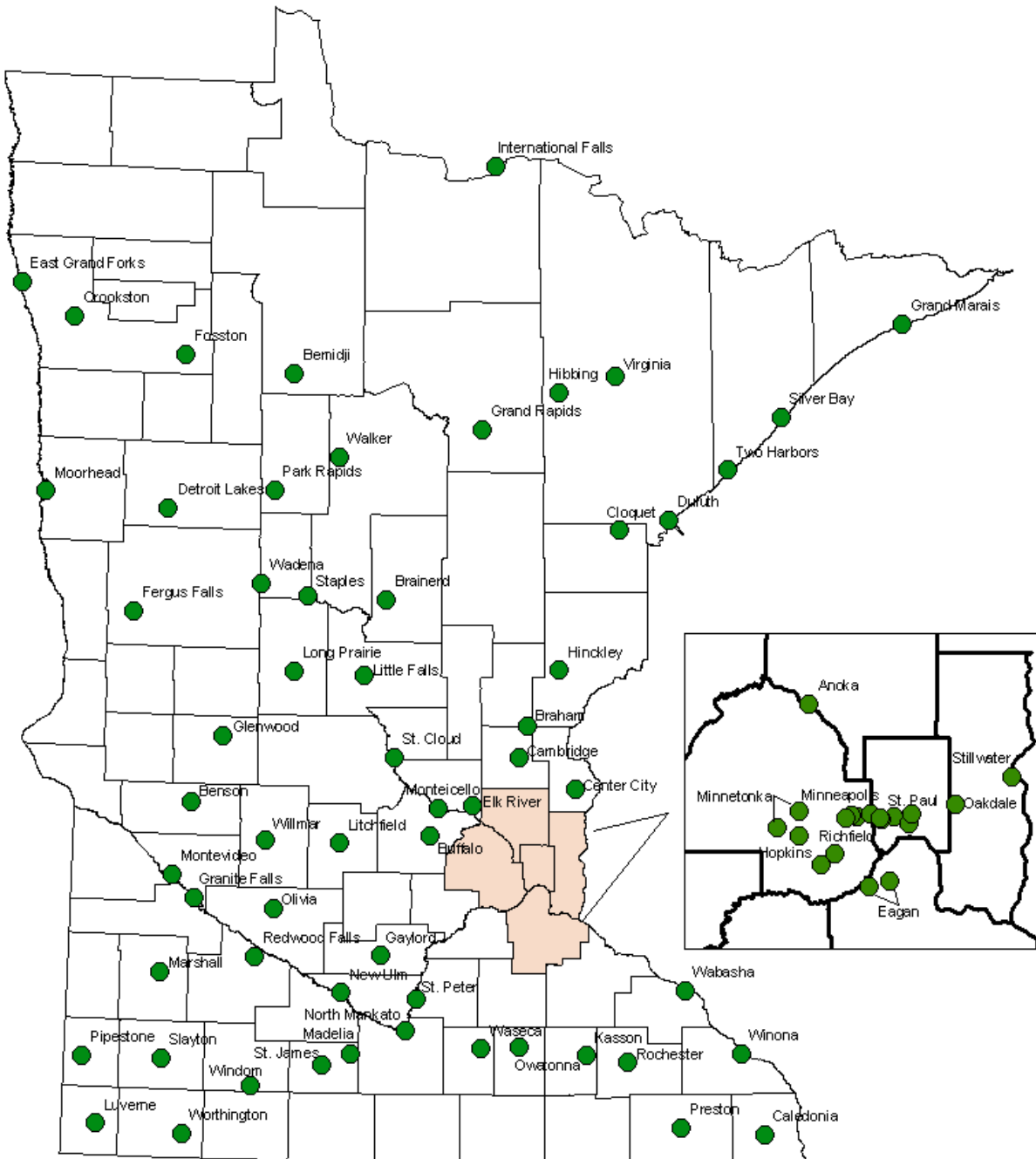
Designations are calculated using a ratio of total full time equivalent (FTE) to the total population of a given geographic area; or a ratio of FTE available to a specific population (ie: population at 200% poverty).

Data Source: Minnesota Department of Health; Office of Rural Health and Primary Care



Map 2

Community Mental Health Centers and Satellite Programs Minnesota 2003



Source: Office of Rural Health and Primary Care