RECOMMENDATION TO MEET MENTAL HEALTH NEEDS OF CLIENTS IN COMMUNITY HEALTH CENTERS

by

RAYMOND A. PIENCZYKOWSKI

A clinical project submitted in partial fulfillment of The requirements for the degree of

MASTER OF NURSING

WASHINGTON STATE UNIVERSITY
Intercollegiate College of Nursing

MAY 2005
To the Faculty of Washington State University

The members of the Committee appointed to examine the Clinical project of RAYMOND A. PIENCZYKOWSKI find it satisfactory and recommend that it be accepted.

Sheela Choppala – Chair

Carla Crockford

Dawn Doutrich
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iv</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>2</td>
</tr>
<tr>
<td>CONCEPTUAL FRAMEWORK</td>
<td>4</td>
</tr>
<tr>
<td>APPLICATION OF MODEL TO COMMUNITY HEALTH CENTERS</td>
<td>6</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>12</td>
</tr>
<tr>
<td>RECOMMENDATIONS</td>
<td>15</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>19</td>
</tr>
</tbody>
</table>
Recommendations to Meet Mental Health Needs of Clients in Community Health Centers

Abstract

By Raymond A. Pienczykowski
Washington State University
May 2006

Chair: Sheela Choppala

Applying the Neumans System Theory to community health centers, this paper explores internal and external stressors which serve as barriers in community health centers providing comprehensive care. Mental health and substance abuse top the ranks of clinical encounters in community health centers. A literature review and preliminary analysis of a larger study reveal that primary care providers in community health centers find it difficult to meet the mental health needs of their clients. This paper will also demonstrate the impact of unmet mental health needs, such as depression, anxiety, and substance abuse, on primary care providers. Recommendations, in particular, the integration of psychiatric mental health nurse practitioners in community health centers are discussed.
Recommendations to Meet Mental Health Needs of Clients in Community Health Centers

Raymond Pienczykowski

Washington State University, Vancouver
Introduction

The prevalence of mental health and psychiatric disorders are increasing worldwide (Kessler, 2005). Many underserved clients utilize community health centers (CHCs) as their primary source for mental health services. Mental health is the fifth most common concern for clients seeking services at a CHC (Proser, 2004). Clients who present to CHCs with mental health issues and substance abuse issues outnumber any other clinical encounter; totaling 2.9 million clinical encounters in 2003 (Proser, 2004). Because CHCs are required to report primary diagnoses rather than reporting both primary and secondary diagnosis for reimbursement, an underreporting of mental health and substance abuse visits may occur as well (Proser, 2004). The purpose of the paper is to provide evidence of need and recommendations regarding ways to meet the mental health needs of clients in CHCs. This paper will also demonstrate the impact of unmet mental health needs, such as depression, anxiety, and substance abuse, on primary care providers.

Interviews were conducted with primary care providers currently working in free clinics and CHCs in the Portland/Vancouver area who were participants in a larger study on the recruitment and retention of providers in CHCs and free clinics. Questions about mental health needs and issues related to those needs were asked during the interviews. Provider reports corroborated information found in the literature regarding the high percentage of concurrent mental health needs of clients. Some of the interviewees reported that up to 40-50% of their clients presented with depression, anxiety and problematic substance use. Also, preliminary analysis of the data gathered revealed that
these diagnoses along with other psychosocial issues, impact the ability of physicians and adult/family nurse practitioners to provide comprehensive care.

Specific themes that emerged in the preliminary analysis were these:

1. There are no resources to get clients specialty care, including psychiatric services.

2. Primary care providers acknowledge that many of their patients suffer from a mental health issue, but for lack of time, ability, or resources to treat it, they focus on general medical issues instead.

3. Primary care providers are reticent to prescribe psychotropic medications but they do so because their clients' do not have any other source.

4. Primary care providers describe feeling “frustrated” or “hopeless” when they can't provide or access quality mental health care or psychotropic medication for their clients.

5. Primary care providers consistently state that it would be a “tremendous asset” to have a psychiatric specialist on staff at their clinics.

These themes gathered from a sample (n=9) of providers are congruent with the issues delineated in the literature.

A review of the literature reveals an abundance of studies regarding the barriers to meeting the psychosocial issues of CHC clients. The numbers of CHC clients are rising. Due to a number of factors, the tenure of providers who deliver care is unstable. A study conducted in Puerto Rico on managed mental health care in the public sector showed increasing turnover rates among providers (Albizu-Garcia, 2004). The paucity of literature addressing the impact of unmet needs on the providers and their willingness to
continue their work in CHCs indicates that further research in this area is needed. According to an exploratory study in New York City neighborhood health centers (N=33) by telephoned interviews of administrators, social workers, and medical doctors revealed providers are doing their best to care for clients with mental health needs but it is only a matter of time before the increased numbers in CHCs will put too much stress on these providers, which could ultimately influence their desire to work at the clinics (Rizzo, 2005).

Model

Neuman’s systems theory is the theoretical framework guiding this paper. The premise of this model is that an organism or unit tends to maintain homeostasis despite the internal and external forces that try to disrupt its natural balance. Propositions of this theory state each individual client system is unique, with an inherent response to stressors known as the basic structure. Stressors exist consciously and unconsciously that affect the individual. The ability for one to shield themselves against stressors depends on physiological, psychological, sociocultural, developmental, and spiritual aspects of the person.

According to systems theory there are lines of defense within a system. These normal and flexible lines of defense, with a continuous exchange of energy, move the system towards or away from stability. The normal line of defense is how the client-system responds to stressors in a state of wellness or stability. This normal line of defense is an evolutionary product from previous experience to stressors and the system’s ability to adapt to these stressors. The flexible line of defense is the first line of defense in the client-client system which protects the normal line of defense. The capacity of stressors
breaking through the flexible line of defense depends on the provisional state of the person, e.g., hungry, sleep deprived, scared.

Neumann describes health as the best wellness at any given time. To maintain health Neumann states there is primary, secondary, and tertiary prevention all carried out by intervention. Primary prevention is carried out by attempting by reducing stressors and risk factors; health promotion is an example of primary prevention. Reducing the reaction to a stressor once a reaction has been initiated is secondary prevention. Utilizing the lines of defense the client has and strengthening them through collaboration with the client is an example of intervention in secondary prevention. Tertiary prevention is intervention in the reconstitution phase where progress is moving towards optimal health (Parker, 2006).

Neumann has suggested that this theory be applied to systems or units as well. Within the context of this paper the Neuman systems model will be applied to view the CHCs as the client. The basic structure of the CHC is to provide comprehensive care to the public. Primary care physicians are embedded in the normal line of defense of CHCs. Once primary care physicians become overwhelmed with the high psychosocial demands CHC clients present with, PCPs then function in the flexible line of defense as well as the normal line of defense. Primary care physicians attempting to meet the mental health needs of clients are one of the flexible lines of defense protecting the basic structure of the CHC which are marginally effective. According to Neuman’s model, the system must achieve homeostasis through normal lines of defense. Based on the model, CHCs normal line of defense is to utilize administrative organization as well as 1:1 provision of care to meet the specific needs of clients. In this case, the specific need can be met via specialized providers. Interventions can be implemented before or after lines of resistance
have been breached. Many of the mental health issues are being overlooked for several reasons and it is apparent community health care systems are currently unable to provide the comprehensive care that is needed. A restructuring of the current system may need to be implemented to better meet the complex needs of the people this system serves.

The purpose of this paper is to bring to attention the need for increased numbers of psychiatric nurse practitioners in community health settings. The integration of psychiatric mental health nurse practitioners in CHCs can decrease the burden of primary care health providers by using their skills in treating mental disorders, including prescribing, psychotherapy, psychoeducation, and case management. Increasing the numbers of psychiatric nurse practitioners in CHCs could possibly prevent attrition of current community health care medical providers. Community health centers often, if not always, use a multi-disciplinary approach in the care of their clients. A review of the literature shows little mention of psychiatric mental health nurse practitioners being a part of that multi-disciplinary team.

Application of Model to Community Health Centers

In application of the model, this literature review explored several stressors that threaten the integrity of CHCs and the ability to deliver comprehensive care. The stressors discussed are lack of specialty providers, client stressors, provider stressors, and administrative limitations. The goal of the CHC is to provide comprehensive care to the population it serves. The lack of mental health specialists in CHC cause the primary care providers’ role in the normal line of defense to weaken. Primary care providers’ attempts to meet the mental health needs of CHC clients are minimally effective as flexible lines
of defense. There is a need for psychiatric nurse practitioners to help regain optimal functioning of CHCs. In the following section, each aspect of the model is discussed.

**Lack of specialty providers**

Individuals in rural areas compared to those living in urban areas had more hospital admissions for mental health problems and significantly more numbers of suicide attempts. Rural individuals who had received specialty care for depression abolished the difference in hospital admissions between urban and rural individuals (Rost, 1998). A major barrier in community health care settings is in referring patients to specialty mental health services due to the lack of providers in behavioral health (Proser, 2004). Considering patients' preference to being treated for mental health in a primary care setting, psychiatric nurse practitioners in primary care may not just be a useful strategy, but it may be a cost effective one as well (Marks, 1985).

There is a lack of providers in the community setting. According to the National Association of Community Health Centers (NACHC), not only are there a lack of general care providers in rural and CHCs, there is also a severe shortage of specialty providers. Less than 10% of the counties with population under 2,500 have a psychiatrist (NACHC, 2005). In the year 2000, only 5.3 percent of CHCs had one full time mental health specialist (Figure 1). Based on these facts it would appear difficult for CHCs to adequately meet the mental health needs of CHC clients. Obviously, there is a need to increase not only the number of general care providers, but specialty care providers integrated within the community clinic as well. Since 1999 to 2005, medical visits increased by 6.8% whereas dental visits grew 35.6% and mental health visits increased by 75.9% (NACHC, 2005). With the ever increasing mental health visits it seems there is
a disparity between the needs of CHC clientele and services available e.g., psychiatric services.

A study on medical nurse practitioners’ perceptions on their ability to assess a mental health problem was conducted (Torn, 1996). The study was conducted by mailing questionnaires to 130 Royal College of Nursing qualified nurse practitioners (Torn, 1996). The results revealed that a majority of the providers were not comfortable with the assessment of mental health problems and the need for the development of psychiatric nurse practitioners roles in primary care. A main reason for the development of a psychiatric nurse practitioner role was clients’ mental health needs were not being met.

Client Stressors

Stigmatization. A review of the literature shows approximately one out of five people will be affected with a mental disorder within their lifetime (Haber, 2004; Ingoglia, 2005; Vasiliadis, 2005). General health care plays an integral role in meeting the mental health needs of the clients they serve (Ustun, 1995; Edlund, 2004). Many times the CHC will be the only facilities an individual will have treat their mental illness and other times CHCs will refer to specialty mental health facilities.

Mental health was originally addressed in the public health system but has now evolved into a separate specialty away from public health (Ingoglia, 2005). This separation of services poses a challenge to the public health system to provide comprehensive care for communities. Due to the potential of being labeled, going to a specialty mental health provider may not be an option for some (Corrigan, 2004; Liggins, 2005). This labeling phenomenon individuals experience is a shift in belonging, to a subgroup of human beings or as different (Becker, 1986; Thesen, 2001). Mental illness
continues to carry a stigma making it especially hard for clients to talk about psychiatric issues in a CHC environment or accept referrals to a specialty mental health facility (Williams, 1999).

According to Corrigan, public and self stigmatizations are two factors which influence an individual to not seek and participate in mental health treatment. To avoid the label and escape public and self stigma a person who might benefit from mental health treatment may not seek help. Negative attitudes towards persons with mental illness, and within people themselves about mental illness serve as a barrier to seeking and maintaining mental health treatment (Corrigan, 2004).

Provider Stressors

*Lack of time.* People who come into a rural or CHC can have various issues from physiologic to psychological, but with providers seeing many patients in a short period of time, often mental health needs are not mentioned by the client or screened by the provider (Tylee, 2005). Additionally, clients come to CHCs with competing demands. When there is a physical issue, the odds of psychological issues being addressed during the visit are reduced (Rost, 2000). Moreover, a client with unremitting depression who presents to a primary care provider with a new physical complaint significantly reduces the odds for a change in treatment in their persisting depression (Rost, 2000). According to a study utilizing grounded theory qualitative method to analyze audio taped interviews of five patients and five health professionals, when individuals who already have a psychiatric illness such as depression present to a general care provider for a medical condition/concern, the provider was less apt to believe the patient had a serious medical illness (Liggins, 2005).
In a study of 1202 low-income African American women by computer assisted telephone interviews, those who had sustained relationships with their providers in primary care were more apt to be screened for depression during their visits (O’Malley, 2003). It appears that therapeutic alliance is important before a patient will disclose such personal information.

CHC clients have compounded psychosocial issues which plague this population. Psychosocial problems of CHC clients include limited finances, emotional distress, cultural practices affecting health, medical non-compliance, difficulty adjusting to illness, substance abuse, shelter, medical insurance, household violence, and isolation (Rizzo, 2005).

There is little, if any research regarding the impact of psychosocial issues/mental health needs on providers’ ability to continue working with the underserved population in CHCs. A study of New York City neighborhood health centers looked at the perspectives of administrators, social workers, and medical doctors in the identification and addressing of psychosocial problems. This study took into account the ability of the participants to meet the psychosocial needs of CHC clients, how effective their efforts were perceived, and how they felt they would meet the client’s needs in the future (Rizzo, 2005). The consensus of the study was that physicians, social workers, and administrators are simply doing the best they can to provide quality care and provide psychosocial services. However, without increased revenue and the ever increasing number of the uninsured, providers will not be able to provide the current quality of care (Rizzo, 2005).

Limited Specialty Knowledge
A study of forty-seven community based physicians’ ability to recognize depression by video taping four interviews with patients who met standardized criteria for major depression; not one physician was able to extract enough symptoms to make a DSM-IV diagnosis (Badger, 1994). Several studies have shown approximately half primary care providers know most DSM-IV criteria (Bowers, 1992; Rapp, 1989; Shao, 1997). A study on dual diagnosis revealed only a small portion of 261 medical doctors had the knowledge to assess and plan interventions for those with co-existing substance use and mental health disorders (Fraser, 2002).

A study conducted by Kaiser Family Foundation on the stress put upon community health center providers showed almost every center interviewed reported increased numbers of clients presenting with mental illness or problems with addictions (Rosenbaum, 2004). These increased numbers are creating longer waiting periods for individuals to be seen by a provider. Many of the centers stated that they are unable to meet the level of intervention needed for these clients.

**Administration Stressors**

**Cost.** Mental health services have historically been underfunded and continue to be so (Ingoglia, 2005). A majority of CHC clients are covered by Medicaid. According to a study of neighborhood health clinics in New York, providers stated that despite a sliding fee scale, the health clinics do not generate adequate revenue to cover the cost of service provided to uninsured clients (Rizzo, 2005).

According to the 2007 Fiscal year budget proposal President Bush’s New Freedom Commission on Mental Health states mental health services in the United States are fragmented. Under the reform proposal, states will use these allocated funds to
transform their mental health care systems and will track and report on the results of these investments. During a panel discussion on February 16, 2006 on health care initiatives President Bush supported an increase in CHCs. Since 2001, the administration has funded 800 new or expanded centers and estimates the funding of 400 more within the next two years (Strengthening Health Care, 2006). According to a random sample of 100 executive directors in community and migrant health centers in the United States, District of Columbia, and Puerto Rico conducted via telephone revealed sixty-four percent state their was inadequate staffing to service all who need care (NACHC, 2000).

According to the NACHC, eighty-eight percent of community health care centers cannot recruit the appropriate amount of providers secondary to inadequate funds (NACHC, 2000). CHCs having a full-time psychiatrist consumed a significantly larger portion of funding than CHCs without a psychiatrist but with some form of mental health staff in place (Figure 2). CHCs are cost-effective care by reducing specialty care referrals and less hospital admissions. These savings are passed on to federal and state Medicaid expenditures. Re-investing these savings back into CHCs to support adequate staffing for services needed would allow community centers to serve more clients effectively, comprehensively and continue to save federal dollars.

Discussion

Integrate Psychiatric Mental Health Nurse Practitioners in CHCs

Related to the Neumann Model, primary care providers are a normal “line of defense” for CHCs when dealing with medical illness. When primary care providers treat mental illness, they serve as flexible line of defense for CHC. The mental health needs of CHC clients are apparent. Responding administratively to the evidenced needs of the
client would strengthen the normal lines of defense in CHCs and protect the basic structure of CHCs. To strengthen the normal lines of defense, specialized providers are needed to deal with the specific needs of the client. Integrating psychiatric nurse practitioners in CHCs is an intervention in primary, secondary, and tertiary prevention. Primary prevention recognizing CHCs could improve their delivery of comprehensive care by integration of psychiatric nurse practitioners in the normal line of defense.

Adding PMHNPs into the CHC environment would allow for increased collaboration between specialties. PMHNPs seeing clients in the CHC and address mental health issues would constitute secondary prevention. This reduces the reaction of the system to the stressors, e.g., fills void of specialty providers, addresses unmet client needs, reduces burden to primary care provider, and is most likely cost effective. Reconstitution of the CHC in the movement towards optimal health, meeting the complex needs of clients is tertiary prevention.

Psychiatric nurse practitioners are trained to provide a broad range of psychiatric services outlined in the American Nurses Association, *Scope and Standards of Psychiatric Mental Health Nursing Practice*, including but not limited to psychiatric and physical assessment, psychotherapeutics, psychopharmacology, and treatment evaluation (American Nurses Association, 2002). The use of psychiatric nurse practitioners’ holistic approach can also be a cost effective measure in reducing the recidivism in visits for clients presenting with somatic complaints when the real underlying concern may be depression or anxiety (Tylee, 2005). Many of these mentioned services PMHNPs provide are comparable to the services of a psychiatrist (Caverly, 1996).
Research in the area of cost analysis of psychiatric nurse practitioners in CHCs is needed to address this as a viable possibility in providing more complete patient care and in reducing health care gaps. A review of the literature reveals little is known about psychiatric nurse practitioners in collaborative roles in community health centers. Not only is an inquiry of cost analysis of the psychiatric nurse practitioner needed, but also of the quality outcomes of these services. Looking at these two components is necessary for change to occur.

**Targeted intervention and behavioral therapy**

Nursing is based on the theory of holism, treating the physical, psychological and social aspects of an individual. Take for example an individual with depression. Looking beyond the bio-physical and bringing in the psychological and social aspects can guide treatment. Looking at an individual in such a way enables a broader range of therapeutic interventions such as cognitive behavioral therapy. Cognitive behavioral therapy has been shown to be equally effective in efficacy with mild to moderate depression as antidepressants (Gillam, 2002).

Behavioral group therapy is suitable for persons suffering from a variety of problems including depression, anxiety, and substance abuse, some of the most common mental health issues which present in a community health center. Some of the advantages of group therapy include but are not limited to: peer reinforcement, group brainstorming, experience new behaviors in a controlled milieu, development of good social relationships, and feedback from peers which can be more accepted than if coming from the therapist him or herself. Group therapy is equally if not more cost effective than individual therapy (Corey, 2000). Follow up on patients with mainly phobias and
obsessive-compulsive disorder after one year shows these patients were appreciably improved after receiving behavioral psychotherapy from a psychiatric nurse therapist than routine treatment from a general practitioner (Marks, 1985).

Recommendations

Providers are doing what they can to meet the needs of their patients, typically working within a multi-disciplinary team. A study of health care professionals in neighborhood health clinics in New York City state they currently perceive that they are meeting the psychosocial needs of their clients. The increase in clients and insufficient funding has these health care professionals pessimistic in their ability to continue to meet clients’ psychosocial needs in the future.

With the prevalence of mental illness and substance abuse topping the reasons for clinical encounters, it is apparent there is a need for expansion of psychiatric services (Proser, 2004). Seventy percent of community health centers have some sort of mental health treatment or counseling (Proser, 2004). CHCs that do not directly provide mental health services will often provide referrals under “formal” arrangements (Proser, 2005). Considering the sheer volume of mental health and substance dependence encounters in these centers and the stigmatization of psychiatric diagnoses, it would be an effective solution to integrate psychiatric nurse practitioners within the CHC and meet the need at the source. This integration of PMHNPs would prevent the loss of clients during the referral process.

Current models of delivering mental health treatment in CHCs are referral, co-locations, collaborative, and finally integrated care. The referral model of health care may lose patients throughout the referral process. Despite the barrier of travel and expenses
associated with it, there is the stigma associated with being referred to a preferred specialty mental health service. Co-locations, refers to mental health services that are provided in a separate location. That model runs into similar problems to the referral model.

Integration of psychiatric services within the CHC will provide much better results than the previous models. Some benefits would be: better detection of mental illness, cost effectiveness in treatment, faster and more accurate diagnosis, increased communication and collaboration, and education and learning across healthcare disciplines (Katon 1990; Von Korff, 1998; Washington Community Mental Health Council, 2002). More detailed information of which community health care centers provide which model of care is obligatory.

Specialized mental health services also necessitate more expenditure (figure 1, figure 2). A look into integrated models and the inverse cost savings (e.g., less referrals, less emergency room admissions) is needed to truly see the cost benefit of this model.

Based on the evidence presented here there are significant benefits to utilizing PMHNPs in CHCs. Future research should be directed toward the collection of evidenced efficacy and quality of PMHNP in CHC settings, cost/benefit analysis, and outcomes with CHC clients. With these recommendations the needs of clients and providers would be met, resulting in an effective, more optimal functioning CHC.
Mental Health and Substance Abuse Services at CHCs (Cost)

Figure 1. Source NACHC
Mental Health and Substance Abuse Services at CHCs

Minimum Staffing Levels At CHCs

Figure 2. Source NACHC
References


Rost, K., Nutting, P., Smith, J., Coyne, J., Cooper-Patrick, L., Rubenstein, L. (2000). The role of competing demands in the treatment provided primary care patients with major depression. Arch Family Medicine, 9, 150-154.


