

Marriage and Family Therapists Expand Access to Mental Health Services in Rural Areas

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ABSTRACT

Access to behavioral health services in rural areas is severely hampered by a shortage of qualified professionals. Contrary to past assumptions, research indicates that master's level mental health professionals are more common in rural settings than doctoral-educated practitioners. A nationwide comparison of marriage and family therapists (MFTs) to psychiatrists shows a significantly higher prevalence of MFTs in rural and frontier counties. Targeted information suggests that other master's mental health professionals may also be more prevalent in rural areas. In spite of the geographic availability of trained master's level practitioners in rural areas, access to their services may be limited because of health care reimbursement policies that do not recognize these providers. This study shows that removing policy barriers that limit access to master's mental health professionals will increase the availability of behavioral health services in rural settings.

INTRODUCTION

Rural areas suffer from a significant shortage of mental health professionals (e.g., Hartley, Ziller, Lambert, Loux, & Bird, 2002; Vanek, 2002; Merwin, Hinton, Dembling, & Stern, 2003). However, the extant research on availability of mental health professionals in rural areas has primarily focused on psychiatrists and psychologists. There has been no comprehensive geographic analysis of the core mental health disciplines, defined by the U.S. Health Resources Services Administration (HRSA) as psychiatrists, psychologists, social workers, psychiatric nurses and marriage and family therapists. Those studies that do exist are limited in scope and may misrepresent the workforce distribution. For example, some studies suggest that marriage and family therapists and other master's level mental health providers have geographic distributions similar to psychologists and psychiatrists (Medicare Payment Advisory Committee, 2002; Gamm, Tai-Seal, & Stone, 2002). The current study demonstrates that MFTs have significantly greater representation in rural counties than psychiatrists, and that other master's educated mental health professionals are more likely to be located in rural areas than their doctoral-trained counterparts (e.g., Baldwin, et al., 2006).

Residents of rural communities face serious problems accessing mental health services (President's New Freedom Commission on Mental Health, 2003). In 2003, there were 55.3 million people living in 2,293 rural counties. This represents over 73% of United States counties and 20% of the population. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that 20% of the general population suffers from a mental illness, and residents of rural areas have similar incidence and prevalence rates of mental illness and substance abuse (Bray, Enright, & Easling, 2003). The primary difference in mental health care between urban and rural residents is that rural communities have little or no access to services and providers – exacerbating the impact of mental illness on these communities (Seekins, 2002). For example, only five percent of metro counties lack mental health services, while twenty percent of non-metro counties suffer from this deficiency (Hartley, Bird, & Dempsey, 1999). The shortage of mental health professionals in rural areas is at the crux of the access problem.

The Office of Rural Health Policy (ORHP) and the Office of Rural Mental Health Research highlighted this problem in a report on rural mental health in 1993 (Wagenfield, Murray, Mohatt, & DeBruyn) by noting that as the United States moves toward macro level health care reform, understanding and responding to the special needs that exist in rural communities becomes critical where rural mental health care is characterized by a lack of available resources as well as practitioners. Ten years later, the same problem was identified by the President's New Freedom Commission on Mental Health (2003): "Although the supply of well-trained mental health professionals is inadequate in most areas of the country, rural areas are especially hard hit" (Goal 5, "Serious workforce problems exist").

In addition to federal studies, government workforce data echo the same theme. In 2003, the Health Resources Services Administration (HRSA) found that 74 percent of the 1,196 federally designated Mental Health Professional Shortage Areas (MHPSAs) were located in rural counties. The MHPSAs are areas lacking a sufficient supply of mental health professionals. MHPSAs are determined by complicated formulas counting the availability of core mental health professionals: psychiatrists, psychologists, psychiatric nurses, social workers and marriage and family therapists (Designation of Mental Health Professionals Shortage Areas). These areas house a large percentage of the country's rural population and core behavioral health providers are not present in many rural and frontier communities (Hartley et al., 1999).

While HRSA includes non-physician providers in its criteria for designation of MHPSAs, most areas are selected based on the ratio of psychiatrists to the population. One of the reasons for this limitation is because of the dearth of national data on the non-physician professions. This deficiency is also exhibited in other studies on the geographic distribution of the non-physician workforce. Those studies that were conducted use different data sources and fail to represent the full complement of providers. Nonetheless, it is clear that "a significant degree of the burden of caring for rural individuals has fallen on and will continue to fall on subdoctoral professionals" (Jameson & Blank, 2007, p. 295).

One of the first comprehensive evaluations of the mental health workforce was done by the National Advisory Committee on Rural Health in 1993. This report indicated that 55% of U.S. counties had no practicing psychiatrists, psychologists, or social workers and all of the counties were rural (Wagenfield et al., 1993). In 1992, the Health Resources Services Administration

indicated that 90% of psychiatric and mental health nurses with graduate degrees were in metropolitan areas (Health Resources Services Administration, 1992). Indeed, Gale & Lambert (2006) note that more than 90% of all psychiatrists and psychologists and 80% of master's-level social workers practice exclusively in metropolitan areas, a trend that has persisted for decades despite efforts to encourage more mental health providers to live and practice in rural areas. Among 1253 rural counties with 2,500 to 20,000 people, nearly three-fourths lack a psychiatrist, 58 percent have no clinical social worker, and 50 percent are missing a master's or doctoral psychologist. The supply of all these professionals is far lower in the 769 counties with fewer than 2,500 people (Gamm et al., 2002).

METHOD

The data for this national study of MFTs and psychiatrists came from two primary sources: 1) the American Association for Marriage and Family Therapy (AAMFT)'s list of independently practicing clinicians which is made up of state licensure lists and augmented by the AAMFT clinical members list when necessary and 2) the Area Resource File (ARF) which contains all the psychiatrists in the U.S. by county based on the American Medical Association's Masterfile (Quality Resource Systems, 2003; www.arfsys.com).

For the states that did not provide county level data, the mailing addresses of the MFTs on the licensure lists was used to determine in which county they resided using the zip code. A commercial mapping program, Business Map 3[©] (ESRI, 2003; www.esri.com), was used to plot these zip codes to determine which county they fell within. In the few cases where zip codes crossed counties the county was determined by plotting the geographical center-point of the zip code area and seeing which county this center-point fell within.

A common definition that we have adopted for this study is to identify non-metropolitan counties as rural. To the extent possible, we attempted to use these same designations for our data. For instance, population in rural areas is population in non-metropolitan counties. However, references from other sources may use other criteria. Counties are delineated as metropolitan or non-metropolitan using criteria developed by the Office of Management and Budget. Generally, a county is classified as metropolitan if it contains a city of at least 50,000 or if it is contiguous to a county containing a city of at least 50,000 and is socially and economically integrated with it. Counties are classified as metropolitan or non-metropolitan based on the 1993 classification for analysis of the 1990s. As of 1993, 837 counties were defined as metropolitan and 2,303 were defined as non-metropolitan. Analysis of 2000-2004 is based on the 2003 metropolitan classification system. By 2003, the number of non-metropolitan counties diminished to 2,051 and metropolitan counties increased to 1,089. Many of the counties shifting from non-metropolitan to metropolitan status were among the fastest growing rural counties. Frontier counties are generally defined as having a population of less than seven per square mile.

RESULTS

The best useable data available showed 43,517 marriage and family therapists and 36,899 psychiatrists practicing independently in the U.S. This represents 15.46 MFTs and 12.93 psychiatrists per 100,000 persons in the U.S. (U.S. population at the time of the analysis was

281,421,906). When comparisons are made between urban, rural, and frontier counties significant differences are evident in terms of the availability MFTs versus psychiatrists (see Table 1).

Table 1. Mental Health Providers by County Type

	MFTs	Psychiatrists	Ratio of MFT to Psychiatrist
<i>All US Counties (n=3141)</i>			
Counties with Practitioners	1601	1417	110% (184)
Practitioner per 100,000 people	15.46	12.93	1.2
Counties with Only Designated Practitioner	504	320	160% (184)
<i>Rural Counties (n=2293)</i>			
Counties with Practitioners	873	715	120% (158)
Practitioner per 100,000 people	5.6	4.4	1.3
Counties with Only Designated Practitioner	422	264	160% (158)
<i>Frontier Counties (n=454)</i>			
Counties with Practitioners	99	46	220% (53)
Practitioner per 100,000 people	7.7	2.9	2.7
Counties with Only Designated Practitioner	68	15	450% (53)

There are 3,141 counties in the U.S. and of these 73% (n=2,293) are considered rural and 15.5% (n=454) are designated as “frontier” counties. Approximately two-thirds of U.S. counties (n=1,921) have a MFT or psychiatrist. MFTs are present in slightly more than half of all U.S. counties, while psychiatrists are in 45%. Thirty eight percent (38.1%) of rural counties have an MFT present, compared to thirty one percent (31.2%) with a psychiatrist. The prevalence of MFTs in the most rural counties (i.e., frontier) is compelling, with twice as many MFTs than psychiatrists (21.8% compared to 10.1%).

The differences are also clear in population comparisons. There are 15.46 MFTs and 12.93 psychiatrists per 100,000 persons in the U.S. In urban counties, the data show a ratio of 17.9 MFTs per 100,000, compared to 15.2 psychiatrists. However, in rural counties there are 25% more MFTs than psychiatrists per 100,000 (5.6 compared to 4.4 for psychiatrists). In the most remote frontier counties, there are two and a half MFTs to every psychiatrist (7.7 to 2.9).

The data also suggest that MFTs and psychiatrists are not always in the same counties. While there is overlap in the rural areas, there are 422 counties (18.4%) with MFTs but no psychiatrists, compared to 264 (11.5%) with psychiatrists but no MFTs. This difference is important when determining availability of mental health professionals, because it shows that MFTs are not only more likely to be in rural areas, but are also more likely to be in those counties that do not have a psychiatrist. In rural counties, MFTs represent 3.8/100,000 residents whereas psychiatrists

represent 2.7/100,000. Additionally, on average there are almost 5 times as many MFTs per 100,000 residents in frontier counties than psychiatrists (5.0 MFTs and 1.2 psychiatrists per 100,000 residents).

DISCUSSION

A challenge to accurately determining mental health professional shortages is the relative lack of data available at the national and the state level (Merwin, Hinton, Dembling, & Stern, 2003). One of the key findings from the Institute of Medicine's report on the future of rural health care (IOM, 2004) was the need for better information on the current supply and types of health professionals. The current study attempts to address this need by providing data about two of the core mental health disciplines (HRSA) – marriage and family therapists and psychiatrists. MFTs are present in nearly 40% of all rural counties and are, when compared with psychiatrists, much more likely to be present in a rural county where there is no psychiatrist present.

Further, an analysis by county of all the core mental health professions in Texas demonstrated comparable comparisons to national figures (Bergman, 2004). There were dramatically more master's degree providers (MFTs, social workers, and psychiatric nurses) in rural counties compared to doctoral professionals (psychiatrists and psychologists) – 56% included master's clinicians while only 31% had doctoral level providers. Further, 23% of rural counties had master's level providers but no doctoral providers. In addition, there were 13 rural counties with only a MFT provider and no other core mental health provider, and 28 rural counties with only a MFT and no psychologists or psychiatrists.

Rural consumers face a variety of obstacles when attempting to access mental health services including stigma, cost, transportation, cultural differences, and most important in terms of the focus of this study, availability of practitioners. One method for addressing the issue of availability is to implement methods for removing barriers to accessing qualified mental health practitioners in rural areas. For example, since Medicare does not currently reimburse MFTs, one study (Hartley, Ziller, Lambert, Loux, & Bird, 2002) recommended an interim policy that would authorize direct reimbursement to MFTs only in designated Mental Health Professional Shortage Areas (the study cites as precedent the policy of the Federal Employees Health Benefits Program regarding any licensed provider in underserved areas). Indeed, since insurers and State Medicaid programs often follow Medicare's lead, even further access to qualified mental health practitioners in rural areas would likely follow.

Another example, as recommended by the National Advisory Committee on Rural Health and Human Services (2004) is the use of fully integrated clinical teams of primary care and behavioral health providers. Such multidisciplinary healthcare teams carry the central value of focusing on the family as the unit of care, with systemic thinking inherent in the delivery of services (e.g., Amundson, 2001). MFTs are the only core mental health discipline whose scope of practice and training are solely based on relationships and family systems. However, current Medicare payment policies also limit access to mental health services at Rural Health Clinics based on provider type as well as reimbursement limitations. Additionally, another example of removing barriers to access is utilization of telehealth technologies which can link rural communities with distant mental health providers (e.g., Bischoff, Hollist, Smith, & Flack, 2004).

Additional barriers occur even after legislative progress has been achieved. For example, within the last couple of years laws were amended for both the Department of Veterans Affairs (VA) and the Department of Defense (DoD) to include MFTs as eligible providers. However, MFTs still face barriers to practice because the VA has not yet developed the MFT Job Classification and clinical credentialing standards, and the DoD has yet to issue regulations or directions specifying MFT participation. These barriers are significant given the critical needs of active duty, reserve, and veterans for clinical services, especially so in rural areas, and the critical shortage of providers needed to deliver such services.

The current study demonstrates that MFTs are present in a significant number of rural counties in the United States. Access to qualified mental health practitioners in rural areas is one of the most significant barriers to addressing the critical needs of rural America. MFTs are recognized by the Health Resources Services Administration as one of the five core mental health disciplines. MFTs are a well trained, highly skilled, diversity competent mental health workforce that can significantly contribute to the behavioral and mental health needs of rural children and families.

REFERENCES

- Amundson, B. (2001). America's rural communities as crucibles for clinical reform: Establishing collaborative care teams in rural communities. *Families, Systems, & Health, 19*, 13-23.
- Azrin, S., Moran, G., Myers, M., Hatfield, B., Mishkind, M., & Peterson, S. (2003, January 7). A report on the public comments submitted to the President's New Freedom Commission on Mental Health. Rockville, MD: President's New Freedom Mental Health Commission.
- Baldwin, L., Patanian, M., Larson, E., Lishner, D., Mauksch, L., Katon, W., Walker, E., & Hart, G. (2006). Modeling the mental health workforce in Washington State: Using state licensing data to examine provider supply in rural and urban areas. *Journal of Rural Health, 22*, 50-58.
- Bergman, D. (2004). Marriage and family therapists serving rural clients. *Family Therapy Magazine, 3*, 32-34.
- Bird, D., Dempsey, P., & Hartley, D. (2001, October). Addressing mental health workforce needs in underserved areas: Accomplishments and challenges. Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Maine Rural Health Research Center.
- Bischoff, R., Hollist, C., Smith, C., & Falck, P. (2004). Addressing the mental health needs of the rural underserved: Findings from a multiple case study of a behavioral telehealth project. *Contemporary Family Therapy, 26*, 179-198.
- Bray, J., Enright, M., & Easling, I. (2003). Psychological practice in rural primary care. In

R. Frank, S. McDaniel, J. Bray, & M. Heldring (Eds.), *Primary Care Psychology* (Chapter 13). Washington, DC: American Psychological Press.

Designation of Mental Health Professional Shortage Areas (n.d.). Bureau of Health Professions, Health Resources Services Administration, U.S. Department of Health and Human Services. Retrieved June 21, 2007, from <http://bhpr.hrsa.gov/shortage/hpsacritmental.htm>

Gale, J & Lambert, D. (2006). Mental healthcare in rural communities. *North Carolina Medical Journal*, 67, 66-70.

Gamm, L., Tai-Seal, M., & Stone, S. (2002, June). White paper: Meeting the mental health needs of people living in rural areas. College Station, TX: Texas A&M University Health Science Center, School of Rural Public Health, Department of Health Policy & Management.

Hartley, D., Ziller, E., Lambert, D., Loux, S., & Bird, D. (2002, May). State licensure laws and the mental health professions: Implications for the rural mental health workforce. Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Maine Rural Health Research Center.

Hartley, D., Bird, D., & Dempsey, P. (1999). Rural mental health and substance abuse. In T. Ricketts (Ed.), *Rural Health in the United States* (pp. 159-178). New York: Oxford University Press.

Health Resources Services Administration (1992). Mental health providers: Supply and distribution. *Rural Health Professions Facts*. Washington, DC: Author.

Holzer, C., Goldsmith, H., & Ciarlo, J. (1998). Effects of rural-urban county type on the availability of health and mental health care providers. In R. Manderscheid & M. Henderson (Eds.), *Mental Health, United States, 1998* (pp. 204-213). Washington, DC: U.S. Government Printing Office.

Institute of Medicine. (2004). Quality through collaboration: The future of rural health. *Committee on the Future of Rural Health Care, Board on Health Care Services*. Retrieved January 15, 2005 from <http://ruralhealth.hrsa.gov>

Jameson, J. & Blank, M. (2007). The role of clinical psychology in rural mental health services: Defining problems and developing solutions. *Clinical Psychology: Science and Practice*, 14, 283-298.

Katon, W., Lin, E., Russo, J., & Unutzer, J. (2003). Increased medical costs of a population-based sample of depressed elderly patients. *Archives of General Psychiatry*, 60, 897-903.

Medicare Payment Advisory Committee (2002, June). Report to the Congress: Medicare coverage of non-physician practitioners. Washington, DC: Author.

Merwin, E., Hinton, I., Dembling, B., & Stern, S. (2003). Shortages of rural mental health

professionals. *Archives of Psychiatric Nursing*, 18, 42-51.

National Advisory Committee on rural Health and Human Services. (2004). *The 2004 report to the secretary: Rural health and human services issues*. Retrieved January 15, 2005, from <http://ruralhealth.hrsa.gov>

Pion, G., Keller, P., & McCombs, H. (1997, October). Mental health providers in rural and isolated areas: Final report of the ad hoc rural mental health provider work group. Rockville, MD: U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

President's New Freedom Commission on Mental Health (2003, July). *Achieving the promise: Transforming mental health care in America*. Rockville, MD: DHHS Pub. No. SMA-03-3832.

Scheffler, R., & Kirby, P. (2003). The occupational transformation of the mental health system: Growing use of psychotropic medications in changing the workforce mix in mental health care. *Health Affairs*, 22, 177-188.

Seekins, T. (2002). *Rural facts: Rural mental health*. Retrieved May 5, 2004 from RTC: Rural, University of Montana Rural Institute Web site: <http://rtc.ruralinstitute.umt.edu/MentalHealth.htm>

Vanek, D. (2002). *Rural mental health*. Retrieved May 5, 2004 from RTC: Rural, University of Montana Rural Institute Web site: <http://rtc.ruralinstitute.umt.edu/MentalHealth.htm>

Wagenfield, M., Murray, J., Mohatt, D., & DeBruyn, J. (1993, April). Mental health and rural America, 1980-1993: An overview and annotated bibliography. National Rural Health Association, National Association for Rural Mental Health.