Rural Psychiatry

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National Context

- Recognition of potential shortage by national groups:
  - American Association of Medical Colleges (AAMC) has suggested a future shortage is looming and has called for a 30% increase in medical school enrollments by 2015.
  - Council on Graduate Medical Education reversed position in 2004 to say there may be a shortage coming.
  - American Medical Association has acknowledged need to increase overall supply as well as improve distribution in underserved areas.
Psychiatry

- First year enrollment 18,000 increase of 2%
- 126 medical schools
- 10 new schools by 2015
- The goal of 30% will be reached by 2017
- Counsel on Graduate Medical education estimated a shortage of 85,000 by 2020.
- 25 Million every 10 years
- 47 millions uninsured
- GME positions did not significantly increase
International context

• Despite improvements in psychiatric teaching, British medical schools have never produced enough graduates aiming for psychiatry.

• The Australian psychiatric profession is failing to attract sufficient numbers of high-quality recruits is growing.

• Pakistan is facing a shortage of psychiatrists; there are about 350 psychiatrists in a country of 150 million
Rising need for Mental Health Services

- Nearly 1 in 3 non-elderly adults experiences a mental disorder in a given year
- Pediatricians report 15% of children have behavioral disorder such as attention deficit disorder, anxiety or depression
Positions

• 2008
  – 1013 positions compared to 1000 in 2007
• 2008
  – a total of 1,069 positions were offered, with 94.8 percent of those being filled.
Psychiatrists per 10,000 Population

Washington DC, 6.48

MA 3.10

Total US 1.34

North Carolina 1.16

SC 1.06

GA 0.99

TN 0.93

ID 0.64

Source: AMA Masterfile; US Census Bureau (http://www.census.gov/popest/states/tables/NST-EST2005-01.xls, .)
Counties without Psychiatrists

- 45 of 56 Montana
- 31 out of 44 Idaho
- 47 of 53 N Dakota
- 56 of 66 in S Dakota
Rural Populations

- **Rural** populations are overall poorer, in worse general health, and less likely to be insured than people in metropolitan areas.
- At the same time, **rural** values such as self-reliance and self-care may delay seeking help.
- Stigma against mental illness may mean that patients don't want family and neighbors to know they are seeing a psychiatrist.
True story

- A Montana county and several surrounding counties had 6 psychiatrists
- None of them were accepting new patients
- None were accepting Medicaid
- One of them announced his retirement
True Story (cont.)

- Six hundred patients received a letter noting that extensive efforts to locate a replacement were unsuccessful and recommendations for referral could not be processed.
- One psychiatrist served a 17 county area in rural eastern Montana (just resigned due to burnout).
• **Psychiatrists**: Issue is less one of overall supply, more an issue of distribution. Residency programs need to maintain or increase number of graduates

• **Child Psychiatrists**: There is a critical shortage and misdistribution of child psychiatrists

• **Psychiatrists and Primary Care Providers**: Many states facing a psychiatrist shortage also face a shortage of primary care providers—may jeopardize access to care for patients with mental disorders
Four Western states that have no medical schools—Wyoming, Alaska, Montana, and Idaho

Brief exposure to rural medicine is unlikely to make much difference.

A training program allotted only one- to four-month rural rotations, but only 5 percent of participating residents went to practice in the countryside.
Supply of other mental health care providers

- Nurse Practitioners: 231%
- Physician Assistants: 140%
- Physicians: 26.3%
Possible Policy Options

• Reduce isolation of providers in rural areas

• Support training in publicly funded settings

• Develop new educational programs for nurse practitioners and physician assistants focused on mental health

• Support and disseminate successful models of care that:
  – Strengthen ties between primary care providers and psychiatrists
  – Provide team-based care and/or consultation models that expand efficiency of existing workforce
Strengthen existing training sites for residents

Identify new sites for psychiatry residents

Expand role of university to integrate care and training

Explore use of rural hospital linkages as training sites

Develop new models for training psych residents while strengthening delivery system
Among the remedies we might consider are to increase the number of psychiatry residents in programs in or near underserved areas encourage residents to take electives in such areas

- Provide more incentives for working in underserved areas
- Simplify the J-1 visa waiver application process for international medical graduates
Telemedicine

• Telemedicine can also bring access to scarce subspecialists or experts, such as child psychiatrists.

• The telemedicine facilities can be shared by more than one specialty, for example, psychiatry and dermatology.
Primary Care/Mental Health Integration

- Add psych/mental health fellowship for selected PA grads
- Recruit students with mental health background into primary care PA and NP programs
- Develop psych/mental health track within NP programs
- One year psych/behavioral health fellowship for family physician residents.
In many cases, need to link incentives for practice in underserved areas to training programs.

Reimbursement for mental health services still an issue in placing providers in underserved areas.
Summary

• Number of positions in underserved areas far exceeds the number of residents seeking to fill them.
• If this pattern continues, there will be more underserved areas without psychiatrists and in turn more people with mental illness not able to get care.
• As psychiatrists and APA members, we need to put addressing this issue at the top of our to-do list.
• We need to address this problem now while it is still manageable rather than just "wait and see."
Thank You