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The Referral Process: Rural Primary Care Physicians' Perspectives on Providing Counseling Referrals

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THE REFERRAL PROCESS: RURAL PRIMARY CARE PHYSICIANS'

PERSPECTIVES ON PROVIDING COUNSELING REFERRALS

by

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The advantages to collaborative care between physicians and mental health care providers have been known for many decades. Rural primary care physicians (RPCPs) are the first professionals that most patients contact when they have a mental health concern, particularly in rural communities. It is therefore important to understand the process that occurs when a referral for counseling is made from a RPCP and the subsequent collaboration that occurs. The purpose of this qualitative study was to generate a model that provides a better understanding of the counseling referral process from the perspective of RPCPs in private practice in the Midwest. A grounded theory approach was used to analyze the data obtained through semi-structured interviews with twelve RPCPs and to construct a model that explains the process that RPCPs engage in when making counseling referrals. The *Counseling Referral Evolution* emerged from the interviews containing nine categories including: Perceived Mental Health Expertise of Physicians, Relationships with Mental Health Providers, Understanding of Counseling, Mental Health Complaint or Diagnosis, Referral Decisions, Method of Referral, Schedule Follow-up, Outcome, and Barriers. Additionally, the RPCPs suggested improvements for better collaboration between mental health practitioners and primary care physicians. Implications for mental health practitioners and primary care physicians are discussed.

Dedication

For my grandparents, Bob and Sue, thank you for spending thousands of hours on the phone with me during my commute to and from the University brainstorming ideas, problem-solving, and engaging in countless conversations. I wish you could be here to share in the celebration; you will both be forever missed.

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Finally, to my participants, thank you for sharing your experiences and thoughts with me. It has been an honor to hear your perspectives and capture your voices on such an important topic. Thank you for your contribution to rural mental health care.

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Chapter 1: Introduction

The divisions between the mental and physical aspects of medicine are deeply rooted and are often highlighted by the negative opinions that some physicians and psychologists have towards one another. Some physicians view psychologists as being less than scientific collaborators as one physician stated, "I have been in business a long time… and you know there are some psychologists out there I thought were just goofier than hell" (Kainz, 2002). Psychologists also contribute to the division, viewing physicians as uncaring, fast-paced scientists who ignore the emotional and psychological needs of their patients (Crane, 1986). However, the advantages of collaborative care to the patient have been proven to far outweigh the petty divisions between physical and mental health care (Segal, Kennedy, & Cohen, 2001; Katon et al., 2002; Unutzer et al., 2002). The 2009 president of the American Psychological Association, James H. Bray, Ph. D. had a major interest in collaborative care of psychologists in primary health care. In his presidential acceptance speech, Bray stated, "Primary care providers treat over 60 percent of all mental health problems without psychologists' help. We can become full partners in the health care arena and particularly in primary health care and effectively prevent and treat the major health problems of our nation – but we need to be there" (American Psychological Association, 2008). The proposed research answers this call to action by providing insight into this contemporary topic through exploring collaboration and the referral process between physicians and mental health professionals.

The advantages to collaborative care between physicians and mental health care providers have been known for many decades (Bibace & Walsh, 1979; Dym & Berman, 1986; Hepworth & Jackson, 1985; Solnit, 1968; Sumerall, Oehlert, & Trent, 1995), and

the current trend toward multidisciplinary, integrated clinics has shown improvement in the referral processes by placing primary care physicians and mental health providers in close proximity in order to facilitate collaboration (Todahl, Linville, Smith, Barnes, & Miller, 2006). However, most of the nation's primary care physicians and psychologists are not part of one of these integrated practices (Yuen, Gerdes, & Waldfogel, 1999), and little research has been conducted to explain how patients from these private primary care offices are referred and arrive for counseling. The goal of the proposed research is to develop a better understanding of and a model to explain the referral process from rural primary care physicians in private practice in the Midwest to psychologists, and the subsequent collaboration that occurs.

Background

Studies have shown as many as 58% of patients with clinical depression may go unrecognized by the primary care physician at any visit leading to delays in treatment and worsening of the underlying psychological problem (Simon, Goldberg, Tiemens, & Ustun, 1999). The path to a referral to mental health care services includes patient consultation with their primary care physician about psychosocial issues, negotiation between the physician and patient, and choice of referral by the physician (Herrington, Baker, Gibson, & Golden, 2003). Once the decision to refer is made, collaborative care between physician and psychologist may range from informal consultation to referral to joint therapy sessions (Hepworth & Jackson, 1985; LeBaron & Zeltzer, 1985; McDaniel, 1995). However, many barriers to mental health referrals from rural primary care exist including reluctance from the patient to accept a referral to therapy, insurance restrictions, lack of available therapists in the area, and time required to make the referral

(Clark, Linville, & Rosen, 2009). In rural areas, shortages in health care providers and mental health care providers, add further complication to collaboration and referral processes (Human & Wasem, 1991; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Previous research has demonstrated that, physicians who were satisfied with their professional relationships with mental health providers were more likely to have an established relationship with a specific mental health provider, receive updates and feedback from referrals, communicate more frequently, and to consult in times other than crises (Gerdes, Yuen, Wood, & Frey, 2001).

Medical and psychology training programs have attempted to facilitate learning about collaborative care by placing family practice residents and psychology interns in joint primary care practice (Anderson & Lovejoy, 2000; Bluestein & Cubie, 2009; Ireton, Racer, & Hafner, 1978; Twilling, Sockell, & Sommers, 2000). Integrated office settings where primary care physicians and psychologists work in the same office have also facilitated collaboration (Brucker & Shields, 2003). However, even in an integrated practice, collaboration has not been absolute; a survey of physicians concluded that while those in multidisciplinary practice with mental health providers reported less difficulty with access to mental health care than other physicians, this group still did not report optimal access to referrals (Kushner, Diamond, Beasley, Mundt, Plane, & Robbins, 2001). In addition, since most primary care physicians and psychologists do not work for integrated health systems (Yuen, Gerdes, & Waldfogel, 1999), it is important to understand the referral and collaborative process outside of these systems, particularly in rural areas. This study seeks to construct a model using a qualitative grounded theory approach to provide insight into the counseling referral process used by rural primary

care physicians in the Midwest and to develop an understanding of the referral process and collaboration between rural primary care physicians and mental health practitioners.

Purpose Statement

The purpose of this study is to construct a model that provides insight into the ways in which rural primary care physicians in the Midwest refer or do not refer patients to counseling. The study seeks to understand the referral process and collaboration between rural primary care physicians and psychologists. "Referral process" is defined here as the process in which physicians make the decision whether or not to provide a mental health care referral to patients who have identified mental health complaints. The study also will explore the potential limitations inherent in the referral process from rural primary care physicians' perspectives.

A qualitative research design was utilized for this dissertation to allow the researcher to develop a better understanding of the referral process from physicians' perspectives. In order for the emergence of a theory or model that explains how physicians make the decision to provide a referral to counseling and what occurs after that decision a grounded theory approach was used. Grounded theory approach permits the researcher to glean an understanding of the counseling referral process from primary care physicians by permitting follow-up questions, clarifications, and new questions to emerge from the physicians during the semi-structured interviews. This allowed for a better understanding of all aspects of the process including limitations, preferences, and potential improvement.

Research Questions

The main questions under investigation in this study are: In what process do rural primary care physicians engage when making a referral to counseling?; and What factors influence referrals and collaboration between rural primary care physicians and psychologists? In order to answer this question, several sub-questions need to be answered as well. Prior research has shown that physician-related issues play a role in the referral process, thus the first sub-question is focused on this issue: What personal experiences affect a physician's decision to make counseling referrals? The next four sub-questions relate to the initiation of the referral: What criteria do primary care physicians use to determine who should be referred to counseling?; How is a counseling referral made?; How do professional guidelines and training impact referral decisions?; and How do patient characteristics influence referral decisions? In order to understand how and why counseling referrals are made, it is also important to understand why they are not made, thus the next sub-questions are: What barriers are involved in the referral process?; and How are counseling referrals similar or different to other types of referrals made by physicians? The next relates to the finality of the referral process: What happens after a referral is made? Finally, the last two sub-questions are designed to provide a deeper understanding of the physician-psychologist relationship and to determine strategies to improve the relationship and the referral process: How do physicians describe their relationships with psychologists?; and What changes could be made by psychologists and physicians to make the process more efficient?

The research sub-questions will be adapted to serve as an interview guide and many follow-up questions will follow based on the physicians' responses. Additionally,

the interview questions may be changed to allow the physicians' perspectives to guide the direction of the study in order to gain a true understanding of their perspectives on the referral practice.

Definitions

Many phrases included in this study have a wide range of usage in the literature. In an attempt to clearly define the use of the terms in this study the following definitions will be employed.

- Rural primary care physicians (RPCPs) – This term will be used to describe physicians practicing in rural areas who serve as primary providers for their patients and routinely serve as the first line of care. For the purposes of this study, pediatricians, family practice physicians, and internal medicine physicians will be referred to as "primary care physicians" because they are often the primary health care providers for their respective patient populations.

- Referral Process – This term describes the process in which physicians make the decision whether or not to provide a mental health care referral to patients who have identified mental health complaints. Although there are many referral processes that physicians undergo on a routine basis, for the purpose of this study, referrals to a psychologist or another mental health care provider providing therapeutic services are the only ones of interest.

- Psychologists – The terms *psychologist*, *mental health practitioner*, *counselor*, and *therapist* are used interchangeably in the literature and throughout this study. A review of the literature by the author revealed little evidence to suggest significant differences in the ways physicians work with mental health practitioners at any

level. If a difference in referrals or relationship with any of these types of practitioners emerges in the interviews, efforts will be made to delineate the types of practitioners.

Delimitations

Collaboration literature between physical and mental health often examines the interactions between primary care physicians and psychiatrists, and between psychiatrists and psychologists. However, for the purposes of this study, these interactions were excluded in order to focus on the interactions between primary care physicians and therapists (i.e., psychologists, counselors, family therapists).

Summary of Chapters

Chapter 1 provides a brief introduction of the study's purpose to develop a descriptive model of the process through which primary care physicians make counseling referral decisions. Chapter 2 provides a review of the literature relevant to the current study including mental health collaboration, physicians' referrals to counseling, and the need for increased collaboration and referrals between physicians and psychologists. Chapter 3 includes a detailed description of the research methodology used in the study, including sampling, interview, and data analysis strategies. Chapter 4 presents the results of the study including the evolution and explanation of the process model. Chapter 5 presents a discussion of the findings, implications, and limitations of the study.

Chapter 2: Literature Review

The concept of collaboration between mental health providers and physicians is not novel; however, physicians and mental health providers have yet to negotiate the perfect collaborative relationship. The review of the literature focused on previous research on the collaboration between physicians and mental health care providers and factors that affect the referral process. A review of the need for collaboration, the referral process, barriers to collaboration and referral, and models of collaboration in practice will be presented.

According to the Institute of Medicine, primary care is "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Povar, 1996). There are two important aspects of psychologists' interactions with primary care physicians: the referral process of getting a potential client from the physician's office to the therapist's office and the concept of collaboration between the physician and therapist. Hinshaw (1995) defines collaboration as "working together in joint intellectual effort toward a common goal and set of objectives".

Collaboration between primary care physicians and mental health practitioners has been explored in many articles and professional organizations have been advocating collaboration for years (American Association of Family Practice, 1995; Backus, 1952; Bibace & Walsh, 1979; Dym & Berman, 1986; Hepworth & Jackson, 1985; Prince et al., 2007; Sumerall, Oehlert, & Trent, 1995). Collaboration exists on a spectrum and may look different in various practices and between individual physicians and psychologists.

The different styles can be categorized as consultation, referral, or joint session/co-therapy (Hepworth & Jackson, 1985; LeBaron & Zeltzer, 1985; McDaniel, 1995). The consultation is a normal part of the physician's work and involves asking the psychologist for their opinion about a specific question that has arisen in a patient's care. Consultation may be an informal conversation between the physician and therapist without involvement of the patient or may be a single session for the psychologist to evaluate the patient to answer the physician's question. The traditional referral is the most common form of collaboration and typically involves the physician sending the patient to the psychologist for management of a problem (McDaniel, 1995). The joint session is the "most powerful method of collaboration" when the physician and psychologist come together and see a patient at the same time (McDaniel, 1995, p. 121). This is especially useful when the physician is having difficulty understanding the psychological aspects of a patient's problem, a psychologist needs additional clarification of the impact of a medical problem on therapy, or the medical and psychological aspects of a patient's health are intimately connected. Patients may benefit from the expertise of each specialist and the collaborative treatment of the whole person (LeBaron & Zeltzer, 1985). An additional form of collaboration, co-provision of care, has also been suggested where the patient-physician and patient-psychologist relationships occur simultaneously over time and the physician and psychologist interact on a regular basis about the patient (Holloway & David, 2005).

Doherty, McDaniel, and Baird (1996) further defined five levels of collaborative interactions between primary care and behavioral healthcare. In level one, *minimal collaboration*, physicians and therapists practice independently and rarely interact unless

a specific problem arises regarding a mutual patient. Level two is *basic collaboration at a distance* where practitioners regard each other as resources and interact frequently about mutual patients by phone or letters, but each practices independently. Level three refers to *basic collaboration on-site* where physicians and mental health practitioners share a mutual location and thus have more interaction, still maintaining separate systems and lacking an in-depth understanding of each other's practice. In level four, *close collaboration in a partly integrated system*, practitioners share information systems, have regular meetings about patients, and have coordinated treatment plans about difficult patients. The most integrated practice is level five, *close collaboration in a fully integrated system*, in which all practitioners have a solid understanding of each others' roles and approach treatment as a team with shared systems and treatment plans and frequent collaborative discussion about patient care (Doherty, McDaniel, & Baird, 1996).

Need for Collaboration

The need for improved mental health care services world wide is a World Health Organization (WHO) initiative, "no health without mental health" (Prince et al., 2007). WHO estimated in 2007 that neuropsychiatric disorders accounted for one third of all noncommunicable disability-adjusted life-years, making the health burden of mental health greater than heart disease or cancer (Prince et al., 2007). As such, there is a need for mental health awareness to be integrated into public policy, health care design models, and the daily delivery of health care. Primary care physicians serve as a first contact point for many patients with mental health care problems, who represent a large number of primary care visits. Physician education focused on the development of interview skills with patients who may have a psychosocial complaint has been

emphasized in residencies, especially in family practice (Pace, Chaney, Mullins, & Olsen, 1995). However, most patient encounters are focused on the medical complaint and ignore the psychosocial element completely (Marvel, Doherty, & Baird, 1993). As many as 58% of patients with clinical depression may go unrecognized by the primary care physician at any visit creating delays in treatment and worsening of the underlying psychological problem (Simon, Goldberg, Tiemens, & Ustun, 1999). In addition, resident physician level of training does not seem to correlate to interviews focusing more on psychosocial concerns indicating that even though physicians are receiving some education in interviewing skills, time limitations and other barriers still exist (Marvel, Doherty, & Baird, 1993). Closer collaboration and an understanding of the barriers involved in referrals may assist patients with mental health problems in receiving needed psychological care.

Even if the physician recognizes the mental health problem exists, the problem is often treated with medication or reassurance from the physician (Pace, Chaney, Mullins, & Olsen, 2004), gaining primary care physicians the label the "de facto mental health care system in the United States" (Reiger, Goldberg, & Taube, 1978). To illustrate, Holloway and David (2005) discussed that some physicians who seem the most aware of psychosocial issues may provide the fewest referrals because they feel equipped to provide mental health services. Other physicians, however, rely on their ability to utilize mental health referrals in rating their ability to treat mental health problems (Yuen, Gerdes, & Waldfogel, 1999).

Both psychologists and physicians have been guilty of viewing the person not as an intertwined mind and body, but rather as separate parts that can be treated individually

in the respective fields (McDaniel, 1995). Collaboration between the therapist and physician can be helpful in treating almost any problem, however, there are several problems for which collaborative treatment has been specifically discussed in the literature. For example, the death of a loved one and the subsequent grief, stress, and bereavement can be a very trying time for a person; thus, the introduction of therapy to those suffering a loss can assist the physician in caring for the family and potentially lessen visits for somatic complaints and emotional concerns (Hepworth & Jackson, 1985).

Treatment of psychosocial issues in children is another area where collaboration between a psychologist and primary care physician is especially important (Cummings & Wiggins, 2001; Greene & Thompson, 1984). One of the earliest experiments in integrated care was the partnership of a group of pediatricians and psychoanalysts who met together to design collaborative approaches to childhood problems (Solnit, 1968). Psychoanalysts joined pediatricians for a joint session with the children and families identified by the pediatrician as needing psychological assistance. Pediatricians reported that the experience was helpful not only with the patients who received care during the study, but also in dealing with psychosocial issues in their other patients (Solnit, 1968). Recognition of psychosocial problems is particularly helpful in children with chronic medical problems who often have emotional distress related to the disease, anxiety about procedures and treatment, and coping with their changed life (LeBaron & Zeltzer, 1985). In addition, chronic somatic complaints are common in children with anxiety about school (Greene & Thompson, 1984). Collaboration with the school psychologist to gain information about the child's interactions at school can be very helpful in the treatment of

a child with somatic complaints. The school psychologist can provide further assistance by providing counseling services to manage the underlying psychosocial complaint that is manifest in somatic complaints (Greene & Thompson, 1984). The treatment of attention deficit hyperactivity disorder/attention deficit disorder is also often initiated by a pediatrician or family practice physician, but collaboration with a psychologist for behavioral intervention may decrease the need for prolonged medical management (Cummings & Wiggins, 2001).

Many psychological problems in adults benefit from a collaborative treatment approach as well. The need for collaboration between physicians and mental health professionals is limitless and benefits to integrative care can be found in the treatment of most major mental health problems due to the efficacy of combination therapy including psychotherapy and the use of psychotropic medications (Enright & Blue, 1989; Lang, Norman, & Casmar, 2006; Roy-Byrne et al., 2005). The treatment of drug and alcohol problems has also benefited from collaboration between the primary care physician and psychologist (Bray & Rogers, 1995). Research on combination therapy is probably best established for the treatment of depression for which potential benefits to combined therapy include improved response to treatment with reduction of depressive symptoms, reduced rates of recurrence, lower medication dosages with fewer adverse side effects, and increased compliance (Katon et al., 2002; Segal, Kennedy, & Cohen, 2001; Unutzer et al., 2002).

Emphasis has been placed on collaborative treatment models in the depressed elderly as this population is quickly growing in the US (Barsa, Toner, Gurland, & Lantigua, 1986; Knight & Houseman, 2008; Koening, 2006; Unutzer et al., 2002). Barsa,

Toner, Gurland, and Lantigua (1986) focused on internists' ability to diagnose and treat depression in the elderly population. The researchers found that although internists fairly reliably recognized the symptoms of depression in elderly patients, their ability to follow through on recommendations for treatment and interventions was lacking, indicating a need for more reliable collaboration. The study also found that the referrals made for counseling were not reliably followed and that the average number of counseling sessions did not meet conventional expectations of counseling for depression (Barsa, Toner, Gurland, & Latigua, 1986). On the contrary, more recent studies have reported physician treatment rates of depression may be lower than 50% with fewer than 10% receiving referrals for therapy (Koening, 2006). This may be partially due to the low number of discussions that are initiated by primary care physicians about mental health issues (Tai-Seale, McGuire, Colenda, Rosen, & Cook, 2007). Of those who are treated, however, collaborative care is more efficacious. In one study 45% of patients treated with combined interventions of medication and therapy had a reduction of depressive symptoms compared to 19% of the control group (Unutzer et al., 2002).

Collaboration between physicians and psychologists is also critically important in the management of the most severely depressed; the suicidal patient. One in three suicide victims has been shown to have contact with a mental health provider in the year preceding suicide, however, this number is far greater for primary care physicians (Luoma, Pearson, & Martin, 2002). Seventy-five percent of victims have had contact with their primary care physician in the year preceding suicide and 45% have had contact within the month (Luoma, Pearson, & Martin, 2002). Involvement of a psychologist in the treatment of a patient considering suicide may provide assistance in assessing,

monitoring, and appropriately referring a suicidal patient to inpatient care if needed (Bryan, Neal-Walden, Corso, & Rudd, 2009).

The treatment of anxiety, phobias, and panic disorders has also been shown to benefit from collaboration between physicians and mental health practitioners (Lang, Norman, & Casmar, 2006). Combined treatment with medication and psychotherapy for panic disorder has been shown to decrease the necessary dosage and frequency of anti-anxiety medication (Enright & Blue, 1989; Roy-Byrne et al., 2005). Close collaboration between the primary care physician and therapist in mutual patients on psychotropic medications may also eliminate the need for additional providers if medication adjustments are made by the primary care physician based on feedback from the therapist (Enright & Blue, 1989; Roy-Byrne et al., 2005). In addition to the benefits of collaborative care in psychological disorders, additional research is available on the benefits of psychological care in a variety of other medical disorders including: coronary heart disease (Kop, 2005); HIV (Law & Buermeyer, 2005); diabetes (Earles, 2005); obesity; and cancer (Gatchel & Oordt, 2003).

Referral Decision Process

Only a few published studies that have attempted to define the referral decision-making process from the primary care physician to counseling. Many of the studies were conducted in the United Kingdom (UK) and therefore may have limited applicability to the United States because of differences in the medical and insurance systems. Herrington, Baker, Gibson, and Golden (2003) developed a model for the referral decision making process in the UK based on a review of the available literature. They defined the model as having three key components: patient consultation with their

primary care physician about psychosocial issues, negotiation between the physician and patient, and choice of referral by the physician. The model is relatively vague and does not discuss specific factors that physicians consider when deciding whether or not to refer a certain patient.

Another study of particular interest to the proposed research explored how general practitioners in the UK make referral and treatment decisions for patients with mental health problems (Knight, 2003). Nine general practitioners were interviewed and presented with nine case vignettes and asked about his or her treatment strategy, reasons for the decisions, and predicted outcomes. The physicians were also given a questionnaire regarding the importance that they place on a variety of factors when making a decision about whether or not to refer patients with psychological problems. The study found that referral decisions were affected by factors related to the doctor/patient relationship, the mental health services available to the physician, and doctor-specific factors including perceived expertise in psychological health (Knight, 2003).

Denelsky (1996) conducted interviews of his colleagues at Cleveland Clinic in order to better understand the referral process and ongoing interactions between physicians, specifically internists and psychologists. He found that the interpersonal relationship between the physician and psychologist was a very important aspect of the referral process. Physicians who had informal, friendly interactions with psychologist were more likely to respect psychologists as professionals and to refer to them when they needed further assistance with a patient. Barriers to referral were created by the internists' tendency to refer patients whom they thought would need medication to

psychiatrists instead of psychologists. However, when the physician perceived the problem may be interpersonal or emotional in nature, they tended to refer to psychologists. The internists' favorably viewed psychologists who provided brief updates, assessments, and plans of care following initial intake of referred patients. They also preferred for the psychologist to make a plan for continued care and intervention. Overall, the internists viewed the work of psychologists as helpful in the care of their patients and appreciated the assistance in dealing with difficult patients. This study contained limitations because the participants in the study were all colleagues of the author and were internists at one specific site, making the validity and applicability of the data to the general health community difficult to determine.

In an attempt to better understand the physician characteristics that lead to patient referrals, Kravitz et al. (2006) designed a study using standardized patients trained to portray a person with either major depression or adjustment disorder. Primary care physicians referred 36% of the standardized patients to therapy. Additional information was also collected which divulged important information about the referral process. The physician provided the patient with referral information to contact the mental health provider only 52% of the time and was more likely to provide the referral if an appointment could be scheduled in less than two weeks. Personal experience with psychotherapy also made the physician more likely to refer the standardized patients (Kravitz et al., 2006). Although it is difficult to predict real-time patient referral rates from the experiences of standardized patients, the information collected about the characteristics of the referring physicians is helpful for future research.

A recent survey of family practice physicians in the United States focused on their referrals to and collaboration with marriage and family therapists (Clark, Linville, & Rosen, 2009). Physicians reported 48% of their patients could benefit from marital or family therapy but estimated that they referred only 12% of their patients. The survey identified several barriers to referrals, which have been previously demonstrated in the literature and will be discussed later in this study, including reluctance from the patient to accept a referral to therapy, insurance restrictions, lack of available therapists in the area, and time required to make the referral. In reference to collaboration with marriage and family therapists, only 3% reported regularly meeting with therapists about mutual patients and 20% reported having no contact after referral. Solutions to improve referrals and collaboration were varied and included having appointments available, improved communication after patient referral, and proximity to physician's office (Clark, Linville, & Rosen, 2009). This survey is very informative to the current proposed research as a baseline of issues to consider when interviewing primary care physicians about their referral practices.

Barriers to Collaboration

One major barrier to collaboration between physicians and psychologists is a lack of understanding each others' roles and the style that the other has in working with patients (Bray, Enright, & Rogers, 1997; Crane, 1986; McDaniel, 1995). Differences in training styles and priorities in patient care may make collaborative care difficult because whereas physicians are often focused on finding a problem in their patients and correcting it, psychologists are often trained to gather a broad range of information and to tolerate uncertainty in their work with clients (Bray, Enright, & Rogers, 1997). Personal

experiences have led some mental health workers to have poor or stereotypical opinions of physicians and thus problems with collaboration and the referral process (Crane, 1986). One family therapist explained the interaction between physicians and family therapists and the difficulties understanding each other's perspective like this:

> The family therapist always involves others in the treatment planning, if not in the treatment itself. The physician does so only if intervention with the individual is insufficient. The pain and suffering encountered by the physician each day require that he or she maintain some emotional distance, whereas the therapist uses warmth and empathy as both joining and diagnostic tools…Physicians are action oriented, trained to take charge of a problem and intervene quickly. Family therapists talk and talk and talk (Crane, 1986, p. 23).

On the other hand, physicians have their own opinions about psychologists that must be considered in the referral process. Kainz (2002) questioned physicians in two integrated clinics and compared the responses of high and low referring providers on questions about referrals to psychologists. One of the main barriers was attitudinal resistance, reflected by one physician who commented:

> I think it's just a cultural perspective that we have entered into that there first of all was a lack of a community where people get help from their neighbors, friends, and family. Then we constructed kind of artificial community of counselors to help [people]…I think that the tools that psychologists use focus people inwards themselves and just perpetuate the problem…; they do not serve to establish those relationships [people] need to help them care for their own problems (Kainz, 2002, p. 171).

Kainz (2002) also concluded that the following factors enhance the referral process and communication between physicians and psychologists: good rapport with a psychologist, knowledge of the psychologist's approach with patients, and being able to pick a particular psychologist whom the physician respects. However, this survey was conducted in an isolated, integrated practice in California, therefore, many of the opinions may not be shared by other physicians.

Another important barrier to mental health care referrals from primary care physicians is the patient's preference to receive mental health care from her/his physician rather than to accept a referral to go elsewhere for more specialized care from a mental health professional (McElheran, Eaton, Rupcich, Basinger, & Johnson, 2004). This has also been expressed as a concern by primary care physicians who believe their patients may feel abandoned when referred to therapy (Pereira & Smith, 2004).

Additional barriers include problems with reimbursement and time restraints. Finding mental health care providers covered by an individual patient's insurance company and subsequent problems with reimbursement can also interfere with the physician-therapist referral process and impede collaboration (Crane, 1986; Freeling & Kissel, 1988; Kushner, Diamond, Beasley, Mundt, Plane, & Robbins, 2001). Time is also a barrier to physician recognition and treatment of mental health problems and referral to mental health care (Marvel, Doherty, & Baird, 1993; Miller, Hall, & Hunley, 2004; Koening, 2007; Pereira & Smith, 2004). With physician schedules allowing only 15 minutes or less for a patient encounter, psychosocial concerns are often not mentioned as discussion will add time to the encounter (Marvel, Doherty, & Baird, 1993).

Dissatisfaction on the part of physicians with the availability and flexibility of mental health providers, including difficulty getting patients in crisis to care (Kaltiala-Heino, Korkeila, Tuori, & Isohanni, 1998) and problems securing appointments for outpatient mental health referrals (Trude & Stoddard, 2003), serves as an additional barrier. A national survey of primary care physicians in the United States concluded that 53% of physicians reported they could only sometimes, rarely, or never obtain appointments for their patients with a mental health care provider (Trude & Stoddard, 2003). Trude and Stoddard (2003) also found that primary care physicians in solo or small group private practice, who represented 50% of the sample, were more likely to report problems obtaining referrals than those in large groups, HMOs, or multi-specialty clinics.

Alternatively, many studies have found that primary care physicians and therapists value the importance of a collaborative relationship and support integration of mental health counseling into primary care practices either through referrals or combined practice (Miller, Hall, & Hunley, 2004; Pereira & Smith, 2004). Overcoming barriers is often best accomplished through communication. Physicians favorably viewed psychologists who provided timely and informative feedback about patients referred to counseling (Freeling & Kissel, 1988). Forming successful collaborative relationships with physicians may require interpersonal skills that psychologists use with clients, an empathetic understanding of the physician's view of patient care, and inclusion of the physician in the ongoing psychological care of the patient (Tovian, 2006).

Models of Collaboration in Practice

Medical schools and residency programs have recognized the need for physicians to have additional training in mental health issues and to include integrated mental health topics into training (AMSA, 2009; ACGME, 2007). Psychology governing bodies have also emphasized training of psychology students in collaborative care (California Senate Bill 983, 1998). One proposed method of improving physician-psychologist collaboration and referrals is to have physicians and mental health providers in training work together in patient care (Anderson & Lovejoy, 2000; Bluestein & Cubie, 2009; Ireton, Racer, & Hafner, 1978; Twilling, Sockell, & Sommers, 2000).

To illustrate, a family practice residency program and a pre-doctoral clinical psychology practicum program created a collaborative training environment with the goal of improving care in the outpatient clinical environment and creating a greater understanding and appreciation of each others' profession (Anderson & Lovejoy, 2000). Residents and Psy.D. students worked together in an outpatient medical clinic to provide care for patients who presented with chronic and acute medical needs. A screening inventory aided in the assessment of mental health needs. At the end of the rotation, the clinic had a significant increase in mental health care referrals and the residents developed a significantly more favorable view of psychology (Anderson & Lovejoy, 2000). Subsequent review of the program also recognized the importance of the collaborative relationships and the impact on patient compliance that arises from each member of the team reinforcing the other's treatment efforts (Bluestein & Cubic, 2000).

A similar rotation paired pre-doctoral psychology interns and medical residents to jointly evaluate all clinic patients (Twilling, Sockell, & Sommers, 2000). The goals of the rotation were to help psychology interns acquire knowledge about the structure of the

primary care clinic, the medical model, and the psychosocial aspects of medicine, as well as, to educate medical residents about psychopathology, the role of the psychologist, and to improve their psychosocial interviewing skills (Twilling, Sockell, & Sommers, 2000). These studies demonstrate the emergence of collaborative practice when physicians and mental health professionals have opportunities to work together.

Information gained from the collaborative experiences of physicians and therapists in training can also be of particular value because it is a measure of emerging mental health practice. A qualitative study of family practice residents and family therapist interns was conducted at a hospital in Florida (Pereira & Smith, 2004). The interviews focused on collaboration, the use of the family systems approach, the referral process, and the perceived role of the practitioner. Although the perceptions of each varied, both groups agreed that interdisciplinary collaboration was important in improving patient care.

One of the more commonly researched models of collaboration is the creation of an integrated practice which includes primary care providers and mental health providers in the same office. Articles theorizing this office design date back many years (Dym & Berman, 1986). In a combined office setting, one study found collaborative contacts were most likely to happen in person and were more likely to be therapist-initiated rather than physician-initiated (Brucker & Shields, 2003). However, even in an integrated practice, collaboration was not absolute as chart records showed that collaboration occurred in only 46% of all cases with a higher rate of referrals reported by therapist recollection. A survey of physicians also concluded that while those in multidisciplinary practice with mental health providers reported less difficulty with access to mental health

care than other physicians, this group still did not report optimal access to referrals (Kushner, Diamond, Beasley, Mundt, Plane, & Robbins, 2001).

A large integrated health system which employs both primary care physicians and mental health providers in Pennsylvania conducted a survey of primary care physicians to better understand the collaboration strength in the integrated health system and to determine which provider and organizational variables were associated with collaboration strength (Gerdes, Yuen, Wood, & Frey, 2001). Survey results about physician attitudes showed that only 43% of physicians were "very satisfied" or "somewhat satisfied" with their consultation relationships with mental health providers in their area. Three factors emerged to explain the strength of collaboration within the integrated health system: relationship quality, primary care physician attributes and attitudes toward managing mental health conditions, and collaborative frequency between primary care physicians and mental health providers. Having a mental health provider onsite was positively related to improved relationship quality and collaborative frequency. Physicians who were satisfied with their relationships with mental health providers were more likely to have an established relationship with a specific mental health provider, receive updates and feedback from referrals, communicate more frequently, and to consult in times other than crisis (Gerdes, Yuen, Wood, & Frey, 2001). This study provided important insight into the collaborative relationships in this integrated health system and into the favorable qualities that physicians value in relationships with mental health providers.

Another study of collaborative health care practice used a qualitative approach to examine the design and perceived benefits of collaborative health care through interviews with office staff (Todahl, Linville, Smith, Barnes, & Miller, 2006). The staff

composition included two family practice physicians, five psychotherapists, a nurse, and an office manager. The study interviewed these individuals in addition to five patients from the office. Questions focused on the environment of the collaborative health care approach. The results of the interviews revealed an office that valued collaboration of therapists and physicians. The referral process was easy and allowed two-way communication between the physician and therapist before and during the course of counseling. This study was largely descriptive but demonstrated a view into a more seamless referral process between physicians and counselors (Todahl, Linville, Smith, Barnes, & Miller, 2006). This study is of particular interest for the current investigation because it shows one end of the spectrum of the referral process and would be good for comparison for future research on the referral process; however, it is limited to the opinions of practitioners and patients within a single practice.

A group in Canada implemented a collaboration model by placing mental health providers in primary care physician's offices and offering mental health consultation in conjunction with the family physician (McElheran, Eaton, Rupcich, Basinger, & Johnsont, 2004). Opinions of patients, physicians, and mental health providers were surveyed at the end of the study. Physicians reported a better understanding of mental health care issues, a perceived greater ability to help patients, and improved understanding of when and where to refer patients for mental health care needs.

Studies about referral and collaborative relationships between primary care physicians and mental health providers in integrated health systems are important because they emphasize the importance of having easy access to a mental health provider. Physicians who are in a collaborative practice have greater opportunity for access and

communication with mental health providers (Fischer, Heinrich, Davis, Peek, & Lucas, 1997). However, this alone does not make the collaborative process perfect. In addition, most primary care physicians and psychologists do not work for integrated health systems (Yuen, Gerdes, & Waldfogel, 1999), thus it is important to understand the referral and collaborative process outside of these systems. This aspect has not been well studied to date in the literature.

Collaborative practices between physicians and psychologists in rural settings have largely been absent in the literature, however, the lack of adequate mental health care in rural areas has been well documented. A study conducted by Thomas, Ellis, Konrad, Holzer and Morrissey (2009) examined mental health care shortages by county and found that rural counties had higher levels of unmet mental health care needs. Specifically those counties had lower numbers of psychiatrists leaving primary care physicians and mental health practitioners as the primary mental health providers. This shortage in rural mental health care is not a novel concept, Human and Wasem (1991) from the Office of Rural Health Policy discussed the shortage, need, and barriers for adequate mental health care in rural areas. They called for training programs, community programs, and policies aimed at increasing the number of mental health providers in rural areas. In order to address the need for collaborative care in rural communities due to the shortage in providers, specifically psychiatrists, this study will focus on collaboration between primary care physicians and mental health practitioners in rural areas.

Few studies have discussed the need for increased collaboration in rural areas despite the need however; Bray and Rogers (1995) designed a program to link rural family physicians and psychologists in the treatment of alcohol and substance abuse. Ten

psychologists and family physicians from Texas and Wyoming were recruited to participate in a series of training sessions on a collaborative approach to alcohol and substance abuse treatment. Surveys on current practices, physician beliefs about psychological aspects of care, and decision style were used to collect baseline data from the providers. Training sessions focused on best practice treatments for alcohol and substance abuse, an understanding of cultural and training differences between physicians and psychologists, preparing families for referrals, and a review of individual provider styles and beliefs. Case examples and role plays were used to help the provider pairs design plans for collaboration in their individual practices. The provider pairs then went back to practice for six months before returning to provide feedback on their experiences. The linkage project successfully created collaborative relationships in eight of the ten physician-psychologist pairs with an increase in referrals from physicians to psychologists for substance abuse and other psychological issues (Bray & Rogers, 1995). The factors that facilitated and hindered collaboration were similar to those found in other research; proximity, previous working relationships, and regular meetings improved collaboration whereas, distance, issues with reimbursement, and patient resistance to referral were barriers to collaboration. While this study focused primarily on the treatment of alcohol and substance abuse, the lessons learned from creating the collaborative relationships can be applied to other aspects of psychological care in rural settings (Bray, Enright, & Rogers, 1997).

The review of the literature revealed several limitations and gaps that this study will attempt to fill. Many articles reviewed were based on personal experiences (Crane, 1986; Nymberg, Selby, Fernandez, & Grimsley, 2000;), literature reviews (Herrington,

Baker, Gibson, & Golden, 2003; Pace, Chaney, Mullins, & Olson, 1995; Tovian, 2006),

and survey data (Clark, Linville, & Rosen, 2009; Freeling & Kissel, 1988; Gerdes, Yuen,

Wood, & Frey, 2001; Kushner, Diamond, Beasley, Mundt, Plane, & Robbins, 200;

Miller, Hall, & Hunley, 2004; Trude & Stoddard, 2003; Yuen, Gerdes, & Waldogel,

1999). Although these approaches help provide some valuable information about the

referral process and collaboration between physicians and psychologists, they fail to

provide an understanding of the primary care physician's voice. A qualitative grounded

theory approach will be used here in order to create a model of the referral process from

RPCPs to mental health care through the eyes of the referring physicians.

In addition, many studies that have provided more in depth understanding of the

collaborative relationships between physicians and psychologists have been conducted in

practices within integrated health systems (Brucker & Shields, 2003; Gerdes, Yuen,

Wood, & Frey, 2001; Kainz, 2002; Nymberg, Selby, Fernandez, & Grimsley, 2000).

Although this practice format may be ideal for fostering collaborative care, most primary

care physicians do not practice in integrated health settings but rather practice in solo or

small group private practices in towns around the country. This study is also particularly

interested in the referral process for physicians in the Midwest who are underrepresented

in previous studies. The Midwest provides a mixture of rural, urban, and suburban

populations. Rural physicians will be particularly emphasized in the current investigation

due to their unique patient populations and geographical limitations to collaboration

(Campbell, Gordon, & Chandler, 2002). In addition, higher rates of depression and

suicide, especially in adolescents, have also been reported in rural areas that contain more

than a quarter of the US population, further emphasizing the need for adequate mental

health care in these areas (Bray, Enright, & Easling, 2004; Campbell, Gordon, &

Chandler, 2002).

      The purpose of this study is to construct a model that provides insight into the

counseling referral process used by RPCPs in the Midwest. The study seeks to

understand and find strategies to improve the referral process as well as collaboration

between RPCPs and psychologists. Additionally, the study will explore the limitations

inherent in the referral process.

Chapter 3: Methods

Rationale for Qualitative Design and Characteristics of Qualitative Research

Qualitative research allows the researcher to talk directly to individuals and to create a complex understanding of a problem from the participants' perspectives without restriction from prior literature or the researcher's prior knowledge (Creswell, 2003). A qualitative approach was best for this dissertation because it allowed the researcher to develop a better understanding of the referral process from physicians' perspectives and would allow fewer limitations. The researcher wanted to learn in what process physicians engaged when choosing whether or not to make a referral to counseling, what barriers were involved in the process, and what improvements could be made to the processes of collaboration and referral to psychologists and other mental health professionals. Because the purpose of this study was to develop a theory that explains how physicians make the decision to provide a referral to counseling, a grounded theory approach was used. Grounded theory approach allowed the researcher to glean an understanding of the counseling referral process from primary care physicians. This allowed for a better understanding of all aspects of the process including limitations, preferences, and potential changes. Responsive interviewing allowed the researcher to develop a deep understanding of the process by developing a relationship between the researcher and the interviewee (Rubin & Rubin, 2005); thus this approach assisted the researcher with developing an understanding of the referral process. Responsive interviewing emphasized the importance of the interviewee's voice and ability to guide the conversation. Although an interview guide was utilized, physicians had the ability to

guide the interview by providing additional information that they deemed necessary to the understanding of their referral practices.

Sampling

For the purpose of this study, purposive and snowball sampling was used to select participants who represented the interests of the group (Corbin & Strauss, 2008; Hatch, 2002). Family practice physicians, pediatricians, and internal medicine physicians practicing in rural areas in the Midwest were chosen purposefully because they represent the ideas and practices of rural primary care physicians (RPCPs). As RPCPs, family practice physicians, pediatricians, and internal medicine physicians were an ideal group as they typically have first contact with patients in need of mental health care services which are often limited in rural areas. RPCPs in private practice with a mental health practitioner on-site were excluded from this study in order to better understand the process involved in providing referrals to external mental health practitioners. Two different specialty areas, pediatrics and family medicine (internal medicine physicians and family practice physicians), were selected in order to understand any differences in the referral process for children versus adults. The researcher sought to recruit a diverse group of male and female participants who represented approximately six primary care physicians and six pediatricians. Additional participants were interviewed until saturation was achieved.

In order to identify participants who meet the selection criteria, a snowball sampling strategy was used. Physicians with whom the researcher had worked were contacted and asked to provide contact information of potential participants who met the following criteria: a primary care physician (pediatrician or family practice physician)

practicing in a rural area in the Midwest. A rural area is defined by the U.S. Census

Bureau (2000) as all territory, population, and housing units located outside of urban

areas and urban clusters, having less than 1,000 people per square mile and outside of the

census blocks surrounding urban areas with 500 people per square mile. Additionally, in

order to ensure a sufficient number of participants, a pediatrician and a family practice

physician with whom the researcher had previously worked agreed to post an email from

me to a professional listserv requesting participation of rural Midwestern primary care

physicians who meet the eligibility criteria. Because additional participants were still

needed after snowball sampling and listserv options were utilized, the researcher

identified other Nebraska physicians who met the criteria. The state physician directory

was examined and eligible physicians were contacted by email or phone to ask for

participation. Potential participants were contacted via email when this information was

available, otherwise this contact occurred by phone. Participants and physicians who

were asked to provide contact information of potential participants were informed that

their participation or lack of participation would in no way affect our relationship.

Physicians who agreed to participate were then contacted by telephone to schedule an

audiotaped 30-90 minute in-person or Skype interview.

Data Collection

Once the participants were identified, they were called to select a time and

location for an interview. Participants were allowed to select a location for the interview;

however, when possible I conducted interviews in the physicians' offices in order to gain

visual data of their work environment that may affect their particular referral processes. I

arranged travel to the participants' preferred locations. Participants were made aware of

any potential risks (i.e., professional liability) involved in participating in the study and were informed of efforts to minimize risks. In order to minimize risks, a professional transcriptionist signed a confidentiality agreement. Transcripts were labeled with pseudonyms and were not linked to participants. Additionally, the primary researcher deleted all material that could potentially identify the participant or the community in which they work. Participants were asked to sign an informed consent form before the interviews began.

Interviews were audiotaped and then transcribed by a transcriptionist who had signed a confidentiality agreement. For confidentiality reasons, participants selected a pseudonym that was not related to their legal name so that they could be assured anonymity. Once saturation was achieved and interviews were no longer yielding new information, a model was constructed (process described below). After the model was constructed, additional participants were included to insure that the model fit with their referral practices, thereby validating that saturation had been achieved. Participants were given the opportunity to review the transcript of their interviews in order to check for accuracy. The researcher took notes during the interviews regarding the content of the discussion, noted observations, and new questions or areas of inquiry. The researcher also kept a journal in order to reflect on emergent learning throughout the study and to evaluate entries for researcher bias.

Interviews and Interview Questions

A semi-structured interview consisting of a few open-ended questions was developed. However, because this study sought to understand physicians' perspectives,

participants were allowed to guide the interview and ask additional questions as the researcher deemed necessary.

1. What practices do you engage in when considering providing a counseling referral?

2. If you do decide to make a referral, how do you go about providing that referral?

3. Are there any personal or professional experiences that affect your decision to make counseling referrals?

Prompts: Do you know any psychologists/mental health practitioners? How do you view or think about psychologists? How do you describe what a psychologist does? Are you more likely to refer to a psychologist, counselor, or social worker? Do past referral experiences affect your practice of making referrals?

4. What criteria do you use to determine who should be referred to counseling?

Prompts: What types of patients receive referrals more frequently and less frequently than others? Are there differences in referrals for males versus females? Is your practice different for adults versus children? Has your practice changed at all since you've been in practice? How are counseling referrals similar or different to other types of referrals you make (i.e., to an ear, nose and throat specialist?

5. How is a counseling referral made?

Prompts: What symptoms need to be present? Does the patient have to agree to a referral? What steps do you take in the process? How is your office staff involved?

6. What barriers are involved in your referral process, if there are any?

Prompts: How do you decide who to refer to? Ease of getting an appointment?

7. What happens after a referral is made?

Prompts: Do you receive follow-up from the psychologists? How do you follow-up?

8. Are there any professional guidelines or training that impact your referral decision?

Prompts: Are there professional standards or practices that govern your referral decisions? What training have you received on providing counseling referrals? What training have you received on mental health care management? Have you worked with a psychologist before?

9. How would you describe your relationship with mental health professionals?

Prompts: Do you commonly refer or collaborate with any psychologists? Are you friends with any psychologists? How can psychologists benefit your practice?

10. Are there any changes that could be made by psychologists to make the process more efficient?

Prompts: How could they make the process easier?

11. Are there any changes that could be made by physicians to make the process more efficient?

Prompts: How could you make the process easier? Would additional training be helpful?

The questions served as an interview guide and prompts were used as follow-up questions based on the physicians' responses. Additionally, the interview questions were allowed to evolve to allow the physicians' perspectives to guide the direction of the study in order to gain a true understanding of their perspectives on the referral practice.

Researcher Bias

It is important to address researcher biases and preconceived notions about this topic at the onset of this study so that you, the reader, can determine the influence on the study. First, the researcher has both a medical and psychology background, having spent three years in medical school and seven years in graduate school studying counseling psychology. Through experiences in medical school, the researcher developed a bias regarding a void of humanism within some medical models. Counseling psychology was found to be a better fit for the researcher to help others. This researcher acknowledges a bias that patients would be better cared for if they were treated as whole people instead a cluster of disease symptoms. It is also the opinion of this researcher that a collaborative approach to mental health treatment is ideal. This researcher has conducted previous literature reviews that indicate a collaborative treatment approach including both psychotropic medications prescribed by a physician and on-going therapy with a psychologist is more efficacious than either treatment alone. The researcher has also given presentations to mental health care practitioners on psychopharmacology and on working collaboratively with physicians, as well as presentations to pediatricians on working collaboratively with psychologists. Additionally, this researcher has worked collaboratively with many physicians throughout graduate education on mental health care issues. While completing the interviews and analysis, the researcher was working in a collaborative health care environment on a college campus. This researcher's experiences with education and collaboration established a unique position of being an "insider" in both medical and psychology communities. The researcher wished to learn from physicians about (a) the decision to make a referral and (b) the referral process after

the decision in order to further investigate what must occur for physicians and psychologists to work more collaboratively with one another when providing mental health care to their patients. The researcher also wished to learn from the participants what the barriers to working collaboratively were and what changes they would like to see in the future. The researcher developed this study believing the information gained would prove useful for both psychologists and physicians.

Data Analysis Procedures

Corbin and Strauss (2008) and Strauss and Corbin (1991) methods of grounded theory research were used to code the transcriptions. The researcher employed all stages of grounded theory analysis, including open coding, axial coding, and selective coding.

Open coding. Open coding is the first step in the data analysis process for grounded theory research as presented by Strauss and Corbin (1991). It involves deriving categories from each sentence of the transcribed interviews. These categories consist of several properties that dimensionalize the data (Creswell, 1998). Sentence analysis was used to assess for the major idea, or concept, from each sentence. Each sentence was then labeled with the major idea of that sentence in the margin. As often as possible, "in-vivo coding" in which the participant's own words were used to label the concept discussed. After labeling each sentence with a concept, the researcher went through and developed each category by naming some of its properties. The properties were then dimensionalized to provide a range. The "flip-flop technique" was also employed in order to assist with analytical thinking and to minimize the influence of bias (Corbin & Strauss, 2008, p. 79). The flip-flop technique consisted of imagining the opposite of the concept being evaluated in order to "open it up." For example, the researcher imagined

what process a physician might go through when diagnosing and treating a sore throat.

For this concern a doctor might feel confident in his/her ability to diagnosis and treat; the

course of evaluation is standard as is the treatment; the doctor has likely experienced a

sore throat; the doctor might feel as if he/she is the final step in the treatment of a sore

throat; there are very few risks or legal issues to consider; and the doctor might feel that

there is no need for a referral or follow-up visit. This process allowed the researcher to

look at the differences that exist in the treatment of a mental health complaint and a sore

throat. After data was coded into categories with dimensionalized properties, the flip-

flop technique was used allowing the researcher to return to the data to further open up

the concepts. Next, the researcher used axial coding.

   Axial coding. Axial coding is the method by which the data is reassembled after

open coding. Connections are made between categories and subcategories. Strauss and

Corbin (1991) described axial coding this way:

> In axial coding our focus is on specifying a category (*phenomenon*) in terms of
>
> conditions that give rise to it; the *context* (its specific set of properties) in which it
>
> is embedded; the action/interactional *strategies* by which it is handled, managed,
>
> carried out; and the *consequences* of those strategies. (p. 97)

Subcategories are linked with categories by consequential causal relationships including

context, intervening variable, strategies, and consequences.

   The first stage of axial coding is defining the phenomenon which is the central

idea that the interactions are directed at managing (Strauss & Corbin, 1991). Next, causal

conditions are identified. Causal conditions are the events that lead to the development

of a phenomenon. The context or specific properties that pertain to a phenomenon is

derived from the dimensions of the properties developed in open coding (Strauss &
Corbin, 1991). After the context is determined, intervening conditions are examined.
Intervening conditions are conditions that foster or hinder the phenomenon from
occurring. After intervening conditions have been identified, then action/interaction
strategies are investigated. Action/interaction strategies are directed at managing or
responding to a phenomenon either in its existing context or under specific conditions.
Lastly, consequences, or the outcomes, are assessed. The outcomes are derived from the
action/interaction in response to or management of a phenomenon (Strauss & Corbin,
1991). The analysis by which categories are linked and developed is complex in that four
distinct steps are occurring simultaneously:

> (a) the *hypothetical relating of subcategories to a category be means of*
> *statements denoting the nature of the relationships between them and the*
> *phenomenon-* causal conditions, context, intervening conditions,
> action/interactional strategies, consequences; (b) the *verification* of those
> hypotheses against actual data; (c) the *continued search for the properties* of
> categories and subcategories, and the dimensional locations of data indicative of
> them; (d) the beginning exploration of *variation* in phenomena, by comparing
> each category and its subcategories for different patterns discovered by comparing
> dimensional locations of instances of data. (p. 107)

The second stage of axial coding consists of asking a series of questions looking
for the relationship between categories. The researcher returned to the data in search of
evidence and events that supported or refuted the research questions. After confirming
that the questions were in fact supported by the data, the questions were reworded as

statements. The variability in statements simply added to the complexity of the

experience. According to Strauss and Corbin (1991), it is within these variations where

the density and depth is added to the theory.

Selective coding. Selective coding, the process of selecting the core category

and systematically relating it to other categories, validating the relationships between

core categories and other categories, and further developing relationships, followed axial

coding (Corbin & Strauss, 1991). This step in the analysis process allowed the researcher

to link, validate, and refine the categories to clarify the emergence of a model that RPCPs

go through when making referrals to counseling. In selective coding, the researcher

developed a story line about the core phenomenon. Other phenomena will be discussed

in implications for future research. The researcher determined the dimensions of the core

phenomenon and then evaluated its relationship to other categories. The researcher then

assessed the story line to see if it followed the paradigm that emerged during axial

coding. Next, descriptive detail was added to the story line. The researcher then returned

to the data to validate the story and the statement that derived from the paradigm. After

combinations and patterns emerged, the story was clarified. In order to ground the data,

theory was presented in diagram form to encapsulate the process. Once again, the

researcher returned to the data to validate the diagram and search for any missing links.

Finally, the researcher interviewed additional participants to see if this emergent theory

fit with their referral process.

Method of Verification, Validity, and Reliability

In order to ensure validity of the transcripts, participants received a copy of the

transcript of their interview and were asked to provide corrections or to confirm the

accuracy of the transcript. The researcher reviewed notes from each interview and the

research journal, which contained journal entries regarding each interview, the

researcher's thoughts about the interviews, and strategies to minimize bias, to examine

potential researcher bias. After nine interviews the preliminary model emerged and

saturation was reached, the remaining three interviews were analyzed to determine if

their process was similar to the process outlined in the model. The preliminary model

was sent to the participants who agreed to review the model and they were asked to

provide feedback on the model, a process called member checking. Two participants

provided feedback on the model and results in the form of a telephone conversation with

the researcher. All of the participants who provided feedback determined that the model

and results accurately represented their processes after examining and talking about each

component. Finally, the themes, findings, and interpretations of the research were

reviewed by an external auditor to assess and verify that each was supported by the data.

The external auditor engaged in a lengthy, thorough process of examining transcripts and

interview recordings to insure accuracy of the transcriptions. Appendix E contains the

external auditor's report.   Additionally, the auditor reviewed open, axial, and selective

coding to insure that the data analysis strategies were comprehensive and accurate

representations of the interview data. The auditor also reviewed all informed consent and

confidentiality records confirming that consent and confidentiality agreements were

obtained as outlined in the research procedures. Lastly, the auditor reviewed journal

entries to evaluate the researcher's attempts to eliminate the impact of biases. After

conducting a lengthy review, the auditor determined that the research was conducted in

an ethical, comprehensive manner as outlined in the methods. Journaling, member

checking, and an external auditor review determined that the influence of researcher bias was minimized and that results and conclusions are transferrable to the counseling referral process of rural primary care physicians in the Midwest.

Ethical Considerations

The main ethical consideration for this study was protecting the anonymity of the participants. In order to protect the participants' identities, pseudonyms were used to identify the tapes and transcripts. No connections between the data and a specific participant are made in the study. In order to minimize coercion of participants, efforts were taken to allow participants to easily opt out of the study without affecting the relationship with the researcher. Additionally, every effort was made to protect privileged and confidential information divulged by the participants. If confidential information was disclosed in an interview, the researcher personally transcribed the interview and removed confidential information from the transcript.

Chapter 4: Results

Emergent Design Elements and Findings

Careful and thoughtful recruitment and interviewing of participants yielded rich,

descriptive data that illustrates the process that rural primary care physicians (RPCPs)

undergo when providing their patients referrals to counseling. Qualitative data analysis

has revealed the main process RPCPs experienced named, *Counseling Referral*

Evolution, as well as the context in which the process occurs and the conditions that

facilitated or hindered movement through the process. Additionally, the RPCPs

generated areas for improvement in the model which will be discussed along with the

hypothesized impact the improvements would have on the model. Conditions associated

with RPCPs movement through the process included their self perception of their own

mental health expertise, relationships with mental health providers, understanding of

counseling, and the nature of the mental health complaint or diagnosis. The most

important contextual element that emerged in the *Counseling Referral Evolution* was the

influence of personal or professional relationships with mental health providers. In

addition, a number of barriers hindered RPCPs movement through the *Counseling*

Referral Evolution.

This chapter begins with a description of the recruitment process, sampling

procedures, participants and sample size. The *Counseling Referral Evolution* process

model will be presented along with the contextual features inherent in the process.

Information obtained from RPCPs during feedback sessions has been integrated into the

model.

Recruitment and Sampling Procedures

Several procedures were utilized to recruit RPCPs into the study as anticipated in the Method. Initially, two physicians with whom the researcher has conducted research previously were contacted and asked to identify eligible pediatricians and family practice physicians (Referral from Physician). They were provided a recruitment email with the informed consent document attached to forward to colleagues who they believed matched eligibility criteria. As physicians contacted the researcher expressing interest in participating in the study they were asked to identify other potential participants. Typically, the researcher was provided with the office phone number of the physician and allowed to use the name of the referring physician when making contact. This snowball sampling technique worked well in generating potential participants, particularly pediatricians.

Additionally, the researcher contacted pediatricians and family practice physicians whom she had worked with or known in some capacity prior to the study who met eligibility requirements (Primary Participant). These physicians were contacted via email or phone call to their office to potentially recruit them as participants. This attempt also yielded several participants, two pediatricians and two family practice physicians. The length of time necessary to participate in the study was frequently discussed by the participants. Participants strongly encouraged the researcher to reduce the time for the interviews to 30-45 minutes due to time constraints of RPCPs. As interviews continued and a pattern of themes emerged, interview time was decreased to accommodate the physicians in the study. Each physician was told that they may need to schedule more time for a follow-up interview if deemed necessary. All of the participants agreed to be available for more time if necessary.

Another form of recruitment was having physicians forward a recruitment email to a statewide listserv of rural physicians. This strategy was specifically aimed at recruiting family practice physicians. This recruitment attempt failed to garner any contacts from interested physicians.

In order to try to gain a more racially or ethnically diverse group of participants, the researcher identified several potential participants, both pediatricians and family practice physicians, from a statewide printed listing of rural physicians provided by the first participant's nurse. The researcher then called the offices of individuals, leaving messages with office staff and nurses about the study. This strategy failed to generate any return calls from potential participants. The most common reason given by the doctors or nurses when they declined participation was the time commitment required by the study.

The researcher also asked colleagues native to rural, Midwestern areas for potential contacts, which generated a list of eligible participants (Rural Midwestern Colleague Referral). Several colleagues agreed to forward study information to the physicians or a person working in the office of the physician. This method proved useful only when RPCPs were contacted initially by colleagues and encouraged to contact the researcher. Finally, participants generated from any of the methods were asked to forward study information to colleagues who they thought might be interested (Secondary and Tertiary Participant Referral). This recruitment attempt proved successful in recruiting both pediatricians and family practice physicians.

Eighteen RPCPs, ten pediatricians and eight family practice physicians, were screened via email or phone for the study. Of those, sixteen physicians, ten pediatricians

and six family practice physicians were eligible. The recruitment sources of the sixteen

RPCPs are summarized in Table 4.1.

Table 4.1 Summary of Recruitment Sources

Recruitment Source	Number of Participants
Primary Participant	4
Referral from Physician	7(4)
Secondary Participant Referral	2
Tertiary Participant Referral	1
Rural Midwestern Colleague Referral	2(1)

Of the sixteen RPCPs who met eligibility criteria, two family practice physician and two

pediatricians who verbally agreed to participate, later declined participation or did not

return phone calls prior to the interview. Three of the RPCPs, who declined or failed to

return phone calls were referred by the initial physicians who agreed to help with

recruitment (Referral from Physician). One person identified by a colleague who grew

up in a rural Midwestern town declined to participate based on the time commitment

involved with the study (Rural Midwestern Colleague Referral). This resulted in twelve

participants, eight family practice physicians and four pediatricians.

The recruitment strategies successfully screened out most physicians prior to

contact. However, two physicians were screened and deemed ineligible for the study.

One of the physicians contacted through a colleague who grew up in a rural Midwestern

town did not have experience as a primary care provider, only as an emergency room

provider. The second physician screened out worked in an office with a psychologist on

staff full-time.

The researcher initially planned on recruiting an even number of pediatricians and family practice physicians in order to accurately depict any difference in the *Counseling Referral Evolution* with children versus adults. However, as the theory began to emerge after several interviews, it became clear that age of the patient was not a crucial element of the process, as the researcher had initially considered. Therefore, pediatricians who agreed to participate beyond the initial six the researcher intended to recruit were allowed to participate in the study in the place of the remaining two family practice physician slots.

Sample Characteristics

As mentioned previously, qualitative research allows the investigator to create a complex understanding of a process from the participants' perspectives by talking directly to individuals without restriction from prior literature or the researcher's prior knowledge (Creswell, 2003). Based on the screening criteria, the RPCPs in this study composed a well-defined group who demonstrated a range of experiences as rural, primary care providers practicing in the Midwest. The in-depth investigation and analysis of the range of experiences among a defined group of RPCPs practicing in the Midwest was the vital component of this study allowing for the understanding of a specific phenomenon, the *Counseling Referral Evolution*.

The twelve RPCPs recruited for the interviews represented a homogenous sample across the following characteristics. All of the participants were primary care physicians, either pediatricians or family practice physicians, practicing in a rural, Midwestern area. Additionally, the participants *did not* work alongside a full-time psychologist practicing in the same office.

Within this well-defined group of RPCPs, a range of diversity and professional training was captured. Four of the participants were family practice physicians who treat patients from birth to death and eight of the participants were pediatricians who treat patients from birth through college. Four participants identified as male and eight participants identified as female. All participants identified as Caucasian; however, one participant identified ethnically as Asian Indian and another as Egyptian. The remainder of the participants identified as European American.

The number of years of practice in a rural community ranged from 1 to 13 years with an average number of years practicing in a rural community 4.08 years (*SD* = 4.12*)*. The sample was primarily composed of physicians who graduated from Midwestern medical schools, with the exception of one participant who graduated from a foreign medical school in Asia. Nine of participants also completed residency in the Midwest, whereas two completed residency on the West Coast and one completed residency on the East Coast. Appendix A contains a summary of the participant characteristics.

Sample Size

According to Strauss and Corbin (1991), saturation is an important criterion that is utilized to determine the appropriate point to discontinue sampling. Saturation is reached when no new information is emerging from the interviews and each relevant category or code has enough information to conduct in-depth analysis. The concept of saturation is paralleled by the concept of information redundancy (Lincoln & Guba, 1985). Similar to saturation, information redundancy indicates that sampling should cease when no new information is being gleaned from the participants. Lincoln and Guba (1985) stated, "In interviewing members of some particular group it is usual to find

that a dozen or so interviews, if properly collected, will exhaust most available

information" (p235).

Careful documentation took place at each stage of analysis in to determine the

appropriate sample size. Analysis began after the second interview with open coding.

Open coding is the first step in the data analysis process for grounded theory research as

presented by Strauss and Corbin (1991). It involves deriving categories from each

sentence of the transcribed interviews. These categories consist of several properties that

dimensionalize the data (Creswell, 1998). Beginning with the first two interviews, the

investigator first used sentence analysis in which each sentence was analyzed to assess

for the major idea, or concept, from each sentence. For example the sentence, "The

bottom line is that if they can't see people that are in the area, then there aren't a lot of

options," was open-coded with the term "limited options". Next, sentences were labeled

with the major idea of that sentence in the margin. As often as possible, "in-vivo coding"

was used allowing the participant's own words to label the concept discussed. In the

previous example, "in-vivo coding" was utilized. After labeling each sentence with a

concept, the researcher then went through and developed each category by naming some

of its properties. Appendix G contains the *open-coding* scheme. Simultaneously, the

investigator began linking the data with *axial coding*. *Axial coding* is the method by

which the data is put back together. Connections are made between categories and

subcategories. Subcategories are linked with categories in a series of relationships,

defined by phenomenon, causal and intervening conditions, context, interactions and

consequences (Strauss & Corbin, 1991). Appendix G contains the *axial coding* scheme.

The first stage of axial coding is defining the phenomenon which is the central idea that the interactions are directed at managing (Strauss & Corbin, 1991). The phenomenon is the referral decision. Next, causal conditions were identified including RPCPs' expertise, relationships with mental health providers, understanding of counseling, mental health complaint. Causal conditions are the events that lead to the development of a phenomenon. The context or specific properties that pertain to a phenomenon is derived from the dimensions of the properties developed in open coding (Strauss & Corbin, 1991). The context for the referral decision are high versus low awareness of limitations treating mental health concerns, moderate versus low experience treating mental health concerns, high versus moderate knowledge of standard of care with regard to mental health, moderate versus low training in mental health care, many versus no individual experiences in counseling, many versus few friends or family who are mental health providers, many versus few known providers in the community, many versus few nurses or partners who have relationships with providers in the community, high versus low knowledge of counseling from personal/professional relationships with mental health professionals, high versus low knowledge of counseling from partners, high versus low severity of complaint, adult versus child age, high versus low need for counseling. After the context is determined, intervening conditions are examined. Intervening conditions are conditions that foster or hinder the phenomenon from occurring; these include the lack of relationship with mental health professionals, availability of providers, cost of mental health care, patient compliance, and value of feedback. After intervening conditions have been identified, then action/interaction strategies are investigated. Action/interaction strategies are directed at managing or

responding to a phenomenon either in its existing context or under specific conditions. The action/interaction strategies include method of referral and scheduling a follow-up visit. Lastly, consequences, or the outcome, are assessed. The outcomes are derived from the action/interaction in response to or management of a phenomenon (Strauss & Corbin, 1991).

The second stage of *axial coding* consists of asking a series of questions to look for the relationship between categories. Following this step, the researcher returned once again to the data in search of evidence and events that supported or refuted the questions. After confirming that all of the questions were in fact supported by the data, the questions were reworded as statements. This is not to say that for each question the same response was elicited from the transcriptions, but rather that the data confirmed the relationships. The variability in statements simply adds to the complexity of the experience. According to Corbin and Strauss (1991), it is within these variations where the density and depth is added to the theory. Simultaneously, as *open coding* and *axial coding* were being conducted on later interviews, the investigator was beginning to use *selective coding* to link and refine the categories.

Selective coding, the process of selecting the core category and systematically relating it to other categories, validating the relationships between core categories and other categories, and further developing relationships, (Strauss & Corbin, 1991) followed axial coding. This step in the analysis process allowed the investigator to link, validate and refine the categories to clarify the emergence of a model that RPCPs go through when making referrals to counseling. In selective coding, a story line was developed about the core phenomenon. Other phenomenon will be discussed in implications for

future research. Next, the dimensions of the core phenomenon were determined and then its relationship to other categories was evaluated. The story line followed the paradigm that emerged during *axial coding*. Conditions led to the phenomenon which is affected by context and led to action/interaction, which led to consequences.

After the first nine interviews were *open coded*, *axial coded*, and *selective coded*, no new categories were emerging. The remaining interviews only supplied further description to the categories that were already in existence. This is the point at which saturation was reached (Strauss & Corbin, 1991). *Selective coding* was continued with the initial nine interviews, saving the three remaining transcripts to use as test cases after *selective coding* was completed and the model was formed to insure saturation and information redundancy were attained.

As data analysis continued, descriptive detail was added to the story line. The investigator then returned to the nine transcriptions to carefully examine the categories in order to validate the story and the statement that derived from the paradigm. Combinations and patterns emerged and the story was clarified. In order to ground the data, theory was laid out in a diagram form which encapsulated the process. Once again, the investigator returned to the data, using the three uncoded transcriptions to validate the diagram and search for any missing links. The same coding process was incorporated with the three remaining transcriptions, slight variations within categories were present, but no new categories emerged confirming that saturation had been reached. The new data worked to further dimensionalize and provide description to the categories and model. Sampling was determined complete after conducting interviews with twelve RPCPs, based on the depth of data provided, the lack of new information emerging from

the last three interviews, and the rigorous analysis which uncovered a rich, detailed process specific to all of the RPCPs in providing counseling referrals.

In order to further validate the model, the model and description was sent to two of the RPCP interviewees for review. Participants were asked to examine the model and the description for congruency with their counseling referral process. They were encouraged to give feedback and remark on areas where the process was inaccurate or not defined clearly. Neither of the participants remarked on any errors and endorsed that the model accurately depicted their process.

The Model: Counseling Referral Evolution

The rich and illustrative descriptions provided by the RPCPs in the study provided the basis for a theory, or model, explaining the process in which RPCPs engage when providing referrals to patients for counseling. The process of the *Counseling Referral Evolution* that emerged from the data explains the components and barriers that rural primary care physicians experience as they strive to treat mental health complaints or diagnoses in their patients. The creation of this model began with the first interview and proceeded numerically through the twelfth interview. After open, axial, and selective coding were used to discover categories, dimensionalize the categories, understand causality between the categories, and put the data together as a process, a map or model was developed to encapsulate the *Counseling Referral Evolution* of RPCPs. By the time analyses had reached the ninth interview, details from the interviews only served to further explain or dimensionalize the existing categories rather than informing new categories. No change occurred to the model after the ninth interview despite systematically going back through the first nine interviews to look for additional

information, coding and utilizing the last three interviews to look for new categories, and having two participants examine the model to evaluate if their processes were appropriately captured by the model.

The model, *Counseling Referral Evolution*, presents the experience that primary care physicians practicing in rural, Midwestern towns engage in from the time a patient presents with a mental health complaint or has a perceived mental health issue to the time, if and when, a referral for counseling is provided to the patient. The model indicates the main process which RPCPs use during the *Counseling Referral Evolution* including three phases, Phase I: Prior to Patient Presentation, Phase II: Patient Presentation, and Phase III: Following Patient Presentation. The progression of Phase I leads to two pathways informing options available to the physician during Phase II. Each pivotal factor along the process is indicated by an orange or yellow box. Barriers that impact the model at several points are indicated by a wheel. Arrows direct movement from one box to another through the counseling referral process. Barriers impede the movement from one box to another as indicated by arrows descending from the wheel. Referral Decision is highlighted as a yellow box because it emerged as the main component of the process. Phase III of the process concludes the *Counseling Referral Evolution* and leads to an outcome of the physician either satisfied or unsatisfied with the process. The process may occur more than once with a patient, with barriers and relationships with mental health providers informing the second round; however, this process was not considered to be part of the core phenomenon and will not be further discussed. The areas likely impacted by improvements suggested by the physicians are indicated by stars in the model. Whereas including potential improvements into a model

is not a typical process in the explanation of this type of model, potential improvement

emerged from the data as an important component to include in the discussion. These

perceived improvements would hypothetically eliminate or nullify the barriers currently

in the model. This may be particularly useful for future research to determine if the

suggested improvements would change the form of the model as hypothesized.

The model presented incorporates all of the information gathered during data

collection including interview data, observations, and feedback from participants on the

model. Each component of the model is described in the following discussion using

quotations from the RPCPs to more accurately capture their account of this process. The

Counseling Referral Evolution process model is presented in Figure 4.1.

Figure 4.1 *Counseling Referral Evolution* Model

Phase I

Perceived Mental Health Expertise of Physicians

Relationships with Mental Health Providers

No

Yes

Understanding of Counseling

Phase II

Mental Health Complaint or Diagnosis

Referral Decision

Barriers

Method of Referral

Phase III

Schedule Follow-up

Outcome

⭐ Areas for improvement
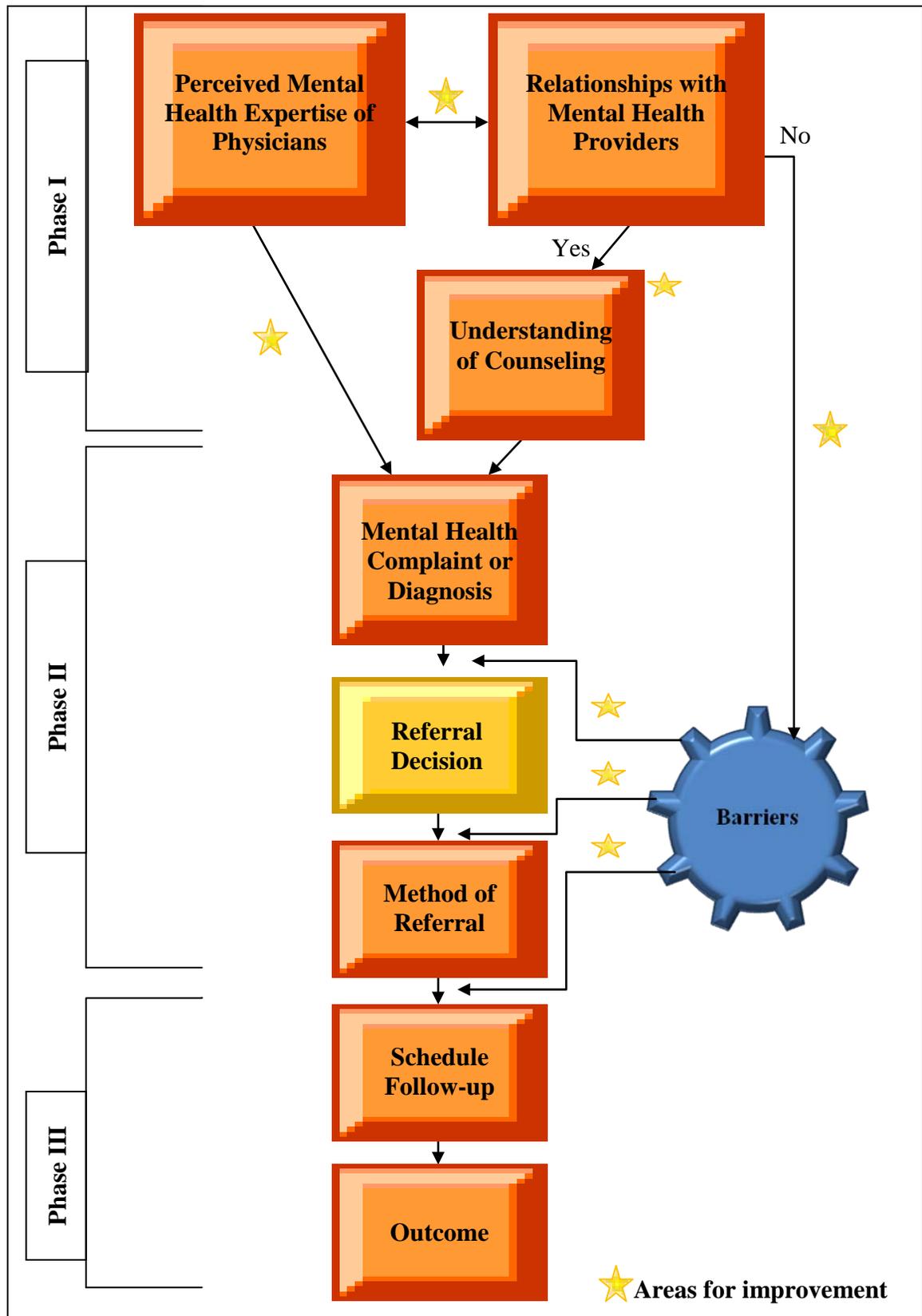
Phase I: Prior to patient presentation. Phase I consists of the process that occurs prior to the patient presenting to their PCP for care. This phase consists of Perceived Mental Health Expertise of Physicians, Relationships with Mental Health Providers, and Understanding of Counseling. As evident in Figure 4.1, Perceived Mental Health Expertise of Physicians has a bidirectional relationship with Relationship with Mental Health Providers both influencing the relationship with mental health providers and being influenced by the relationship with mental health providers. Relationships with Mental Health Providers emerged from the data to have a causal unidirectional influence on the RPCPs understanding of counseling. Also, of noteworthy mention, training did not influence the physicians' understanding of counseling, only personal experience and relationships with mental health practitioners. One participant, Dr. G discussed how her relationships with mental health practitioners influence her practice:

> I think my personal experience would be that I've had more exposure to the
> mental health field over the course of my training and education because of my
> friends in the mental health field. So I think I have a greater appreciation for the
> impact that counselors and psychologists can have in the treatment plan than a lot
> of other people that may train and not have those experiences. I do think for me it
> was more about exposure to other people and to the field that helps with my
> referrals than probably all my training.

Another participant, Dr. J, discussed the impact of her relationships with mental health providers on her knowledge of the counseling process:

> I think I probably gained [my knowledge about counseling] from personal
> experience and knowing friends and family that are in the field and I think it's on

a case by case basis. I see a patient and I think, gosh I think it could be good to

talk about this….I think that's really important and really great when you can say

I know this person on a personal level or a professional level or whatever and this

person is great and I think even being able to express that and saying that you

truly know these people would help can give the patient and the family more

motivation to go even when they are more hesitant.

Perceived Mental Health Expertise of Physicians also has a direct impact on the RPCPs'

process with or without inclusion of Relationships with Mental Health Providers. It is

important to note that this stage is incredibly influential to the process, specifically to

relationships with Mental Health providers. When RPCPs did not have good

relationships with mental health providers, the incidence of barriers influencing the

process was greater. Each of the components of Phase I will be discussed in greater

detail.

   Perceived mental health expertise of physicians. Consistently throughout the

interviews, the participants discussed their level of perceived mental health expertise in

relation to their counseling referral practices. Properties such as RPCPs' awareness of

limitations in treating mental health concerns, experience treating mental health

problems, RPCPs' knowledge of standard of care with regard to mental health, and

RPCPs' training in mental health care emerged in the data.

   For example, Dr. C discussed the *limitations to his knowledge* and his likelihood

of providing a referral:

   If it is someone that I think I straight up can't help, I may send them, probably,

   both to a psychologist and a psychiatrist. In most cases, if it's someone that

comes in that I know fairly well and they have some anxiety issues or some

variety of things that have happened, I will probably try to treat them. But if it is

a new patient who has a long history of…depression, anxiety, bipolar,

schizophrenia, then I'm probably going to go ahead and refer those people. So I

guess that there are a lot of things that play into my decision….Again I guess I am

looking at the severity of the symptoms. If I think it's a severe depression, if it's

something that I don't think that I can completely adequately help with

medication the way it should then I'm going to refer them.

Another RPCP, Dr. J, further described the process of allowing her knowledge and *lack of experience* treating mental health concerns guide her referral practice:

I don't think I have ever started an antidepressant or anxiolytic on anybody

myself, I've helped people do that with the help of a mental health professional

but not starting it myself. I usually start with having a patient go in and talk to

somebody because I feel like there are a certain things that will affect how

somebody feels and how someone will get through a situation like abuse or

addiction. I feel like if I am just going to throw a pill without giving them the

chance to actually talk about it, it may not be the best place.

RPCPs were also guided by their understanding of *standard of care for mental health concerns*. For example, Dr. C, stressed the importance of providing referrals for certain diagnoses based on standard of care:

I think so, I think it is standard of care, when treating a person with bipolar

disorder or other disorders here, it's not just medication alone, but it's also

psychotherapy as well. And sometimes psychotherapy is one thing without

medication. But, certainly, I think standard of care warrants me to make more

referrals to mental health professionals.

The physicians discussed how standard of care dictates that counseling is always

suggested or required in general for adults and children with mood disorder diagnoses.

Dr. D discussed her counseling referral practices with children who present with mood

disorders:

…I almost always suggest counseling for kids that I thought had a mood disorder

because I think such a huge part of that is talking through why you're angry,

you're upset, or down, or whatever. I usually would suggest counseling. I can't

say that all families would take me up on that. I probably had a handful of kids

that just were on medicine and no counseling but I almost always would try to get

both going.

Furthermore, Dr. G described the *standard of care* practice of providing counseling

referrals when treating children with mood disorders:

For depression, it doesn't matter whether or not they get prescribed medication

they all get referred. Anxiety is the same way in kids if they are going to get

medication they definitely get the referral and if they aren't ready for medication

they get the referral anyways. Those don't matter on medication. ADHD is more

of an age thing than a medication thing. …One thing is the black box warning on

antidepressants for children. Essentially, that drives that, no matter what, every

child gets referred to counseling when you're going to start, either before or when

I initiate, antidepressant treatment. And I won't allow a child to be on an

antidepressant and continue prescribing it without attending counseling.

The RPCPs all discussed their standard of care practice of providing counseling referrals to child and adult patients with mental health concerns. For example, Dr. D, validated this process in adults as well:

Number one is mental health diagnoses like depression, anxiety. I always encourage those patients to get counseling because I think that people are over treated medically with pills and just people going willy-nilly on this stuff and not working on their life issues. So that's probably the biggest one for me. …If I definitely knew they had some specific life situations that they were going through, things that added stress, I would push [a counseling recommendation] more.

Another RPCP, Dr. A, discussed his *standard of care* practice of providing counseling referrals to any patient, child or adult, to whom he is prescribing antidepressants:

Well I encourage anybody that I am going to put on antidepressants for any reason. One of my biggest populations is situational depression. You know I sit and pretty much have my spiel known and memorized which is pretty much, 'I can sit here and give you the medication, but unless you deal with the situation it may not get much better.' And I tell them, I say, 'I don't have the time or the expertise to delve into all of these things and I don't want to, I don't need to know the big dark secret or why you're having this issue. That's for somebody that has a lot more training in doing that type of thing than I do." And pretty much if I give somebody an antidepressant, I'm suggesting as well that they see a therapist as well as continue to see me.

Additionally, he went on to discuss his *limitations* with regard to time and expertise discussing mental health problems with patients. Dr. B also discussed the situational depression seen in rural communities and the likelihood she would provide those patients with referrals to counseling based on her experience and knowledge of the research:

> For sure, depression and anxiety are the top things that I would see that I would discuss counseling referral with a patient. In addition to covering my primary practice, I also cover rural clinics in some of the very small outlying communities within an hour of here, and often times those people rarely come to you to discuss depression or anxiety. They come to you because they are having chest pain, or they are not sleeping well or they have a whole variety, like they are having digestive issues, and in the course of the physical exam and the discussion you realize that there is an underlying problem like anxiety and depression. I feel like this is more prevalent in a rural community, it seems like their issues, for example, an elderly patient may be caring for an ill spouse at home, or maybe it is a farmer who hasn't seen a doctor in 10 years, or a young mother without any outlet or support system for other caregivers for her children. Those things are all risk factors for problems with anxiety and depression and I think a lot of times those people just don't know of any support systems in place, so their primary care physician, their family doctor, becomes the first place that they ever talk to anyone about that. Sure. I always offer a referral if I feel like there is a need for potential benefit of psychological, at least evaluation and counseling. … That being said, I almost never start and continue medication without counseling,

without insuring that they follow up with counseling. Because I think the

research is pretty clear, that is a value adjunct to treatment.

Perceived mental health expertise of physicians is also related to relationship with mental

health providers particularly with regard to training. Whereas RPCPs all agreed that they

did not receive any *training* regarding collaboration with mental health practitioners or

providing counseling referrals in medical school, training in residency was an area that

had two dimensions, either having no training or receiving limited training in working

alongside mental health practitioners. Dr. G's experience in residency placed her in the

latter group, but despite her experience making referrals, she did not feel that she

received training in regard to collaboration with mental health practitioners:

> In residency that was the way that we were trained, to make the referral and
>
> include psychologists as part of the treatment too. So yeah, I think that I was
>
> trained. … Yeah, we had behavioral health as part of our residency program. We
>
> had counselors and people like that in inpatient to, so that was certainly
>
> suggested. And I think in the overall training, that was a component. … [In
>
> regard to specific trainings in collaborating with mental health practitioners] no,
>
> other than on the job training and what we learned from our individual preceptors.
>
> But otherwise, I would say no we didn't have any trainings on how to work with
>
> psychologists or counselors.

Dr. G's experience was much more positive than the majority of the RPCPs. Other

RPCPs discussed having limited *training* experiences in mental health collaboration. For

example, Dr. L's experience was lacking in mental health training:

I personally didn't think our behavioral health and mental health training was very

strong at all in our program. I think that's quite common. … Well now that you

jogged my memory, we went to …the state mental hospital. So I take it back that

was pretty interesting training. We would see, again those were hospitalized,

institutionalized individuals. Honestly, that's easier for me to deal with because I

know I can deal with that. I know what I can do with those patients. They go see

a specialist right away compared to the everyday, day in, day out, anger, anxiety,

depression, that kind of stuff. That's what's hard for me, when do you need that

counseling, when do you not? We never learned about that, that I can remember.

Another RPCP, Dr. A, responded to the question about his lack of *training* in this area

frankly, but did have an experience working alongside a psychologist which allowed him

to think about mental health issues:

It sucked if you want to know that truth. My psych rotation that I had to do

during my residency, was geriatric psych. I hated it. …it was absolutely

ridiculous. … We did have a psychologist that did work with us during our

residency on different things. Was it adequate? Probably not. Enough to make

you think and be aware of the psychological or psychiatric undertones of a visit

with somebody, and a lot of it is just on the job training.

Another RPCP, Dr. C, did not have any collaborative experience in medical school or

residency. He discussed the difficulty that his lack of *training* has presented him in his

current practice, making it difficult for him to create relationships with mental health

practitioners:

Well, actually in medical school and residency, no. There was no collaboration between physicians and psychologists, psychotherapists, counselors, or whatever. So it has been a difficult transition. It has been hard too. It's been difficult to get names and phone numbers of providers in the area.

Along with Dr. C, Drs. H, I, K did not recall receiving any specific *training* geared at mental health care that informed their practice or the way they work with psychologists. However, Drs. J and B believed that their experiences in residency working along side mental health practitioners has informed their understanding of what the referral and collaborative relationships should look like. Dr. B described her experience:

I will say that I was very blessed in my residency program…. We had two psychologists that worked in our same clinic and we actually had days that were behavior health days and we spent those days shadowing those psychologists and we got very use to having psychologists in house that we could refer our patients to. So I feel like I really had the opportunity to see how it should be done, so to speak. And I will admit that it doesn't always go that smoothly in the real world. In other words, you don't always get the feedback and the follow up and the good transfer of care, where as these psychologists in residency were so good about calling us if they had seen one of our patients and had a concern about. You know it goes both ways. Sometimes we see patients for physical complaints and we pick up on a potential mental health issue, but it goes the other way. They would be a patient for counseling and the patient would mention that they weren't taking their meds because they couldn't afford them, or their blood sugars had been way off or something and we would always get calls about that and that

makes for a really good collaboration of care that way. But certainly, if I had not

gotten a strong behavioral health training in residency, the whole process would

have been much more difficult and inefficient for me in private practice. And I

think that is true with any referral. If you are not confident in why you are

referring, or to whom you are referring, those referrals aren't as quick to happen or

as quick to be made. So, I think that is really an important thing, I guess, for

primary care residency programs, to make sure that they have adequate training in

that.

The dimensions of mental health training in residency reflect the bidirectional

relationship between perceived mental health expertise of physicians and relationships

with mental health provider. RPCPs in the study discussed their positive relationships

with psychologists whether in training as friends or colleagues, in the community or

though their own experiences in counseling as being beneficial to their counseling

referral practice and overall mental health care of their patients.

Relationships with mental health providers. Relationships with Mental Health

Providers was a "Super Code" with regard to the entire model, meaning that it strongly

influences the entire model and can serve as a facilitator or a barrier. Positive

relationships with mental health providers inform a better understanding of counseling

and make the entire referral process more efficient. A lack of relationships with mental

health providers tends to influence the integration of more barriers into the *Counseling*

Referral Evolution.

The Relationship with Mental Health Provider's concept includes several

properties. Individual experiences in counseling, having friends or family who are

mental health providers, knowing providers in the community, and/or having nurses or partners who have relationships with providers in the community were all properties of relationships with mental health practitioners. Several RPCPs discussed their personal experiences in counseling and in all cases these experiences were perceived as positive and were deemed to make the physician more likely to provide referrals and more knowledgeable about the counseling process. Dr. A described his *experience in counseling* quite favorably, "Personally, yes. I've gone through some counseling with my wife on a couple of different occasions, once when I was in residency and once since I've been out here. It makes me more likely [to refer]." Similarly, Dr. D described the value she perceived in counseling from her own experience:

> Yeah. I was in a long term relationship and got out of it and I went and found a counselor and it was kind of my first experience ever with that and I had a good experience so I guess that probably makes me realize more the value of it.

Another RPCP, Dr. G, discussed the impact of *having friends who are counselors* on her *Counseling Referral Evolution*, even when she is not referring patients to those friends:

> I think [knowing mental health professionals personally] makes a difference for me, but not necessarily the ones that I'm referring to. But it's more my relationships with friends who are in the field over time that give me a better respect for the field and appreciation for what it can do. Not necessarily, right now I don't have any personal relationships with any of the counselors, well one of the counselors I know one pretty well, but other than that I don't know any of the counselors we refer to personally. I have a very positive view of [mental health practitioners'] work and their ability to help. I see miraculous

improvement in kids from counseling all the time and no intervention from

medicine. And most the time unless I feel I can't get them in counseling quick

enough or I feel an immediate danger to their health, I try counseling before I

prescribe medication with the exception of ADHD, which is a very different

thing, in my opinion.

Relationships with mental health practitioners in the community were viewed positively

by the RPCPs. For example, Dr. L discussed a close relationship that she has with a

psychologist in her community:

I really rely on those individuals, so yeah, the more that they're connecting with

me through paper or a phone call. He was wonderful calling the office and

saying, 'can you have Dr. L call me at the end of the day? I want to talk to her

about a referral I saw.' And actually the other thing, what was really helpful too

when I would refer people to him, I would call him. Because I just knew him

after taking care of his kids, so I would just call him. 'I'm sending you someone,

this is his story, I will write you further details in a letter,' because I would

usually send my notes that had a lot of details, or a letter, too. But I would

actually pick up the phone for him, 'this is why this kid is coming to see you.'

Now I know that's not going to happen all the time because you know people.

But that was really nice and it just gave him a heads up on what to be thinking

about. … It's really nice. It's such a nice thing. I just saw a girl yesterday who

clearly needs counseling and I feel so much better to be able to say, "I have

somebody for you." And I know they're going to be able to spend the time it

takes.

Similarly to Dr. L, another RPCP, Dr. C, stated that his *relationships* with providers have

an impact on his referral process. He also went on to describe the different ways he made

connections with providers in his community:

> Sure, yeah. Typically all of the ones that I know, for many years, I have met in
>
> the community whether they are friends or more times than not, there are people
>
> that actually have brought lunch into the office and come and sort of launched
>
> themselves and sort of offered to see a few patients to see what kind of problems
>
> they are having and if they are doing a good job. So we can maybe even get some
>
> patient feedback from them. I think in my situation, that has what happened. It's
>
> been people I have met. It's word of mouth from colleagues or like I said they
>
> have been marketing themselves. There are people that are happy with the level
>
> of quality care that they received I just keep using them.

Another RPPC, Dr. H, described how he established *relationships* with mental health

practitioners in the community in a variety of ways, including though his partners:

> One of them lives nearby me. One of them I go to church with. Some of them
>
> worked here, so they have a lot more interaction with them here in the clinic.
>
> Some of them I have not met yet, I just know from my partners that this is who
>
> we refer to for say, autism testing or something.

In summary, Dr. J's experience provides a nice overview for the impact of a variety of

relationships with therapists on the referral process:

> Yeah, there's definitely one of my best friends that is in psychology, as a career, I
>
> have family member who is a psychiatrist and then you know in my personal
>
> experience there have been times in my life when I have just been overwhelmed

and just gone to a psychologist myself and talked about some things. And I feel

like it really works and yeah, so you know, if anybody is ever asking for it or if I

feel like it will make even a little bit of a difference then I'm always pushing for it

because I really think it works.

Her relationships also inform her understanding of counseling and realizing that "it

works."

Understanding of counseling. Relationships with mental health providers,

regardless of the format, emerged as having a causal relationship with developing a better

understanding of counseling. As discussed previously, RPCPs discussed receiving little

information about psychologists or the counseling process in medical school.

Additionally, they garnered limited information, in most cases, in residency leaving their

relationships with mental health practitioners as their main method of developing an

understanding of counseling and how it can benefit their patients. Dr. G discussed

obtaining her knowledge about counseling from friends who are in the field, "I feel like I

have a fairly good idea of what happens and I can describe what happens in counseling;

describing what to expect when they go, but most of that is from what my friends have

told me who are in the field."

Dr. A discussed learning about counseling and developing relationships with

mental health practitioners from his partners and being able to pass the information and

relationships on to his younger partners:

The one good thing is I joined a partner who was already here, which helps for

when you have something like this and wonder where do I send these people. He

could say here's what I do or here's where I go. And I've been able to do too

with my younger partners who've come in and same deal, they have these

problems and what do you do with them, well here's what I do with them.

Dr. H discussed the evolution of his knowledge and understanding of counseling

developing through his experiences in therapy and working with a psychologist. He went

on to discuss the rewards he feels when he is able to facilitate the referral and better the

lives of his patients:

> Well personally, I have undergone some counseling, so I see the benefit for them.
>
> Then professionally, before starting a practice, I didn't really have that many
>
> patients during residency that had either ADD or any other psychological
>
> problem, and so we didn't really have any sort of practice during residency. Then
>
> as you get into practice, then you start to see, of all the things we do as
>
> pediatricians, that is something we can do that can make a lasting difference for a
>
> patient. It is pretty rewarding to get them treated for those things.

Having an understanding of the counseling process informed the RPCPs' ability

to provide a counseling referral by knowing when their limitations to care for the patients

were reached and what patients would be going through as they begin counseling. Dr. C

discussed his knowledge of how psychologists can benefit his practice, demonstrating an

understanding of how counseling can be beneficial to his patients:

> I don't know if I can answer that in terms of how they benefit my practice, but I
>
> think that just with the quality and effectiveness of care in terms of mental disease
>
> and disorders. Clearly, [psychologists] are more versed in some aspects of
>
> psychology than I am. They can help people in more ways than I can with simple
>
> medication, so I think that they are very, very vital.

Another RPCP, Dr. H, discussed his understanding of the use of counseling when it is outside of his realm of expertise and his ability to provide better referrals by matching clients and practitioners on criteria:

> I consider what services I can provide and where the limits are for me and if this is outside of my realm and could the patient be served better in a clinical setting with a psychologist or mental health practitioner, just so they had more time and it is a more natural environment. So, it is really limited in a pediatric office, in a busy, crazy setting, with people crying in the background and stuff. So usually then, I just consider their age, and sometimes gender is important in who I might send them to, and what type of services they need; I mean, if they need a full psychological evaluation, or if it is just counseling that they need.

As presented in the previous quotations, Relationships with Mental Health Practitioners informs RPCPs knowledge of counseling. RPCPs Understanding of Counseling emerged to have a unidirectional relationship with the Mental Health Complaint or Diagnosis component from Phase II separate from the Perceived Mental Health Expertise of Physicians alone. Therefore, a greater understanding of counseling can be achieved through Relationships with Mental Health Practitioners rather than through the Perceived Mental Health Expertise of Physicians. The Perceived Mental Health Expertise of Physicians, Relationships with Mental Health Practitioners, and the Knowledge of Counseling inform the second phase of the *Counseling Referral Evolution.*

Phase II: Patient presentation. Phase II delineates the components of the *Counseling Referral Evolution* that occur when a patient presents with a mental health complaint or diagnosis, a referral decision is made, and when deemed necessary or

available, a referral is provided. RPCPs enter this stage with their perceived mental

health expertise, relationships with mental health providers and their understanding of

counseling, as well as facilitative or non-facilitative components. When a patient

presents to the Midwestern, RPCP's office Phase II of the *Counseling Referral Evolution*

begins.

      Mental health complaint or diagnosis. The Mental Health Complaint or

Diagnosis component of the *Counseling Referral Evolution* begins with patients

presenting with mental health complaints or presenting with physical complaints and

being given the diagnosis of a mental health issue by RPCPs. Properties of this

component are severity, duration, age, medication intervention, and whether or not

counseling is deemed necessary or sufficient for the issue. Dr. C commented on the

severity of symptoms being an influential component of the counseling referral, "Again I

guess I am looking at the severity of the symptoms. If I think it's a severe depression, if

it's something that I don't think that I can completely adequately help with medication

the way it should then I'm going to refer them."

Another RPCP, Dr. J, addressed the variety of severity and nature of issues that would be

deemed sufficient for a referral to counseling:

> So probably if there is any sort of stressful family situation, I can always bring up
>
> counseling during the interview with the family. A lot of times I think most
>
> commonly it's a teenager that is stressing out and if I do a physical or a discussion
>
> with the teenager alone, they disclose things about family life, school life, drugs,
>
> alcohol, addictive behavior, high risk behavior, depression, and so I will always

refer the teens that are expressing concerns and any other children that have high

stress family situations like divorce or abuse definitely.

Similarly, Dr. A continued discussing the most common situational factors that lack

severity, but require referrals to counseling:

For counseling in general, for most of my patients it's situational. I've got a lot of

situational depression patients that have problems from family problems to

relationship problems to social problems. I don't have the time to sit and counsel

them. Yes, I will prescribe them the anti-depressant … usually with the caveat

that I want you to then go see a therapist as well.

Dr. C responded to the question about what types of mental health complaints he sees

most often and who he refers to counseling:

[I treat patients] typically from birth to the elderly population. So, good question,

I'd say if it's a child, if it's any child, they are going to get referred. If it's a

behavioral problem, if it's a problem with ADHD, if whatever it may be, if it's

any child, it's going to get referred to a psychologist. It's very likely an adult will

get referred as well, just maybe not from the initial move. There are clearly going

to be more complications. I think you know what I'm talking about when I say

that. If it's somebody that I didn't have time to sit there and hear their story, let's

say it took us 15-20 minutes to get to the bulk of it, if I don't feel like I can

adequately treat them, I'm going to refer them and follow them more closely than

somebody that I have had a relationship with for awhile.

 [The] most common [mental health issue I refer is] probably just a depression

disorder. Probably the second one would just be an anxiety disorder, maybe even

more adjustment disorder type of situation. And of course we see patients with

bipolar disorder, some cases of schizophrenia. If I have any concern about

personality disorder, I will refer that to a psychologist immediately.

The types of patients who would benefit from counseling were discussed by many of the

RPCPs. For example, Dr. H discussed the types of patients who he believes that

counseling would be beneficial for and therefore refers to counseling:

Most of [my referrals are] going to be depression, anxiety, ADD, oppositional

defiant disorder, behavior disturbance NOS. Kids that can't get along with their

parents, parents that can't get along with their kids, and there needs to be some

coaching there.

Situational factors and mood disorders were identified by all participants as diagnoses

warranting a counseling referral across all ages. Diagnoses specific to age were autistic

spectrum disorders, ADHD, and oppositional defiant disorder. Children who presented

with autistic spectrum disorders and oppositional defiant disorders were always referred

to counseling when mental health providers were available to provide treatment. Drs. I,

F, and L discussed their difficulties finding providers for both the children and families

with autism. Dr. L stated, "families of autistic children could really use support and or

counseling too. We were really at a loss with that in our town, people would definitely

have to go to a larger city nearby and that was really hard." Distance and availability of

providers are properties of barriers that impact this component of the *Counseling Referral*

Evolution and barriers will be discussed in detail later in this section. After the patient is

determined to have a mental health issue, regardless of the severity, a decision is made to

either provide a referral or not which creates the second component of Phase II, Referral Decision.

  Referral decision. The Referral Decision is a main component of the counseling referral decision evolution. A referral decision is made after the PCP examines a patient with a mental health issue and is informed by her/his own perceived mental health expertise, relationships with mental health providers, and her/his understanding of the counseling process. This stage in the process model is also mitigated by barriers such as availability of providers, patient compliance, cost of therapy, and time until appointments. The properties of Referral Decision are the time of referral and number of referrals provided.

  RPCPs took the mental health concern into account when determining if a patient should be referred to counseling. All RPCPs in the study discussed providing counseling referrals to patients who presented with or who were diagnosed with mental health complaints. However, some physicians chose to wait to provide referrals, whereas the majority chose to provide immediate referrals.

  The *time of referral* varied between RPCPs. Many RPCPs refer immediately and others try medication first. For example, Dr. G discussed his process of generally providing a referral immediately, but at times waiting to see if medication alone is helpful for his patients:

> I think clearly I would refer from the beginning, you know on the off chance that I didn't, I would probably throw them on some medication, again, depending on what sort of thing I am trying to treat. You know, I may see them come back in 4-6 weeks, reevaluate the progress, see how they're doing. Clearly within 6

weeks if they are not feeling significantly better with medicine, I may go ahead

and refer them at that point in time. Sometimes I may wait 3 months. You know,

if there is not quicker progress or their symptoms have worsened then they're

going to get referred.

This process was conferred by Dr. C who stated he typically refers patients with mental

health concerns at the first visit, but in some cases he may provide referrals later.

However, many of the RPCPs preferred the *time of referral* to be at presentation, prior to

beginning medication or in combination with medication to enhance and inform

treatment as Dr. H said:

If they are willing; some kids you know that they are going to need medication,

and they need it before you would even see a counselor, but you would do both at

the same time. Provide them the medication, but with the understanding that

might change, based on what their psychological evaluation brings up. So they

may change what we do, but sometimes we would just tell them we aren't

comfortable starting medicines until you see a counselor and let them know that

the best approach is a combination of counseling and medication for some things,

so they have an understanding of why the counseling is needed. Most people are

accepting of it, but there are few people that would say they aren't going to do it.

RPCPs also discussed the *number of referrals provided* based their decisions to

provide referrals to psychologists or counselors alone or in combination with a psychiatry

referral. When the RPCPs reported feeling confident in treating the mental health issue,

they referred only for counseling, but when they thought that their knowledge was

limited, they provided psychiatry referrals in addition to the counseling referrals. Dr. H

explained this process, "I guess that's another thing. If their medications are outside of my experience, despite that I can look up whatever, you know if I just don't feel comfortable with the medicines, then they need to go see the psychiatrist instead of me." Dr. C discussed providing referrals to both psychologists and psychiatrists when he does not feel capable of treating the person, "If it is someone that I think I straight up can't help, I may send them probably both to a psychologist and a psychiatrist." Barriers, which will be discussed later, create difficulties at this step of the process. The RPCPs discussed the scarcity of providers and the challenge getting patients in to see the local providers. They also discussed the difficulty of communicating with the mental health providers and their difficulty in determining if a patient will follow through with the referral, because, in most cases, the RPCPs or their offices aren't able to schedule an appointment for the patient. The barriers create difficulty in the transition to the next category, Method of Referral, specifically.

Method of referral. The Method of Referral follows the Referral Decision stage when a RPCP decides to provide a counseling referral to a patient with a mental health concern. Properties of Method of Referral are discussion with the patient, who provides the actual referral to the patient, and the method of communication with the mental health practitioner regarding the referral. Physicians in the study indicated that referrals were provided directly to the patient by them, their nurses, or a combination. Additionally, communication with the practitioner was deeply dimensionalized. Commonly, when relationships with the mental health care providers were more established phone calls were made between the providers. When available, albeit rarely, referral forms were utilized as a communication tool between the RPCP and the mental health practitioner.

RPCPs commented across the interviews on their frustration with being unable to schedule appointments directly for their patients as they do with other specialists. Additionally, RPCPs thought that feedback regarding attendance or progress was limited and needs to be improved to more adequately work collaboratively to treat mental health concerns.

According to the RPCPs in the study, the provision of a referral is by the physician, the nurse, or a combination of both. All of the physicians identified having *discussions with patients* prior to the referral being given to foreshadow their counseling experience in order to reduce stigma. Dr. J discussed explaining counseling to her patients prior to giving them the actual referral to lessen the stigma and shock associated with the referral:

> I think the biggest problem to overcome is just kind of pitching the 'Oh, I think you should go to counseling,' or 'oh, I think you would benefit from counseling,'' because there is a little stigma that is associated and it depends on the culture of the patient but some families are a little reluctant when they hear, 'oh counseling,' 'oh, therapy,' 'oh, psychologist,' or 'oh, psychiatrist.' Because you have to present it in a way that you aren't saying, 'oh, you're crazy, oh, you have problems.' You have to present it more as that it is a place to go and let your feelings out and talking about what's going on; and these people are trained professionals that can help you work through that and that is usually how I present it because if you just say, 'oh here's the phone number of a psychologist,' you can sometimes even see it in the expression of the family or the patient, like 'what?

You think I'm crazy?' And I think it's a little more sensitive than saying that I am

going to send you to a specialist, like an ENT.

Dr. C further illustrated his process of *discussing the referral* with patients and informing

them what they may expect from counseling:

But I try to set up a notion that these people are going to have to be open-hearted

and open-minded and a lot of times I even make the comment that this isn't

somebody that you are going to go and say hi to when you see them at a grocery

store or at Wal-Mart. This is somebody that you spill your guts to because it's

private and they are there to help you. That's the point of it. It's just a separate

way of seeking care than when they came to me. I try to tell them that up front

and I've found that generally that helps.

Another RPCP, Dr. H, commented on his process of *discussing with his patients* the ways

in which counseling will inform his treatment and allowing them the opportunity to

continue working with a provider in the community with whom they already have a

relationship:

Well, some families will have somebody they are working with because mental

health problems are within the family as well, so they have somebody they are

working with. Or they have already talked to them about their child, and they

have a good relationship, and so that works for them. Otherwise, I just let them

know what I would expect to be accomplished by sending them to counseling, and

then just ask do you have a preference. And if they don't really have a preference,

then we would send them to someone who we thought would be best for them, or

give them a couple of choices.

The RPCPs interviewed discussed the process of providing the referral to the patient.

Regardless of who provides the actual referral, all RPCPs discussed counseling with their

patients before the referral was given. When *physicians provided the referral,* they

typically provided the patient with the name and phone number of the provider. Dr. A

discussed this process:

> Usually, I [provide the referral to the patient]. I tell them, like we talked about at
>
> the beginning, that we have these things available to you in, at least, our little
>
> corner of the world. And then, a lot of times, I'll provide them numbers to these
>
> places and then the ball is kind of in their court.

Another RPCP, Dr. C, went on to discuss the impact of the relationships with providers

on the *RCPCs provision of the referral*:

> Well, I would say generally speaking, if there's a psychologist I know pretty well
>
> in the community, I will typically just give the patient their business card. If it's
>
> somebody that I am concerned with, I will call the psychologist myself. I'll just
>
> give them heads up and say I'm sending this person to you. I'll even give them a
>
> phone number sometimes if I'm really concerned with a person. For the most
>
> part, I just give the patients a card and say listen, listen, this is someone I know
>
> and trust. I will tell them there is a good psychologist that I have known for
>
> awhile, and I think you should give them a call. Now, that's sort of the referral
>
> process. If it's to a local mental health clinic, it's the same process. I'll give them
>
> the information, I'll tell them if they have walk-in hours and that's about it.

Dr. K echoed the value of the relationship and the benefit of the *physician providing the*

referral and contacting the mental health practitioner directly, "…usually I would call

them myself and talk to them. I would give the patient the card and then we would usually try to send them the notes that we could…. I would just call her up and talk to her." Often due to barriers, this step occurred after a discussion of the availability of providers. Patients were asked if they preferred to stay in town (when available) or see a provider in the nearest city or larger area.

As Drs. A, K, and C discussed many of the physicians preferred to provide referrals to their patients, particularly when they had relationships with mental health practitioners in the community. However, several RPCPs discussed having their *nurses provide the referrals* after talking with the patients about the need for counseling as Dr. G discussed:

> I tell my nurse that the child needs to be referred to counseling. I tell the parent about it. I guess, I talk to the parent about it, I tell them who they're going to go see and I tell them that the nurse is going to come in and give them the phone number and then I tell my nurse and she takes the parent the phone number and calls the office of the counselor and tells them that the parent is going to be calling and we fax over a written referral as well….my nurse has a lot of experience in our community so some of it is what she has known and told me. When I say, 'hey let's get a counselor,' she'll say, 'let's get her to this one because she does….' And so I do rely on my nurse knowing a lot about that and I've had positive outcomes with listening to her.

As Drs. C, G, and K discussed, the *method of communication* with the mental health practitioner is dimensionalized from no communication, to written communication, to oral communication. All of the RPCPs identified this as one of the areas needing

improvement. The RPCPs identified being frustrated with this step limiting the care that they are able to provide their patients. Dr. C's statement provides a nice summary, "Unfortunately, a lot of times, if I give somebody a business card, I know that they are not going to call that person, but we don't have any other options. I think that is disappointing."

   Barriers. Barriers were quite pervasive in the model, and appeared to impact the model at several locations in Phase II. These barriers were directly influenced by a lack of relationships with mental health providers. The properties of this complicating component are availability of providers, cost of mental health care, patient compliance, and value of feedback. The RPCPs commonly identified a lack of psychologists in their communities, specifically a lack of child psychologists. The cost of mental health care or travel to the nearest city was prohibitive for some patients being able to follow through on recommendations or on providers being able to faithfully provide referrals. Patient compliance was a barrier for all of the physicians in the study. Patients were often provided referrals but unwilling to follow through with the recommendations for various reasons (e.g., stigma, financial resources, time). The lack of feedback from providers further complicated physicians' ability to collaborate and continue treating the patient in accordance with the treatment plan. Lastly, participants who lacked close relationships with providers in the community struggled to provide referrals to their patients and/or get their appointment scheduled in a timely fashion.

   RPCPs in the study consistently spoke of the scarcity of local providers and the difficulty that patients sometimes have traveling to nearby cities to seek the treatment that they need. Dr. A illustrated the *availability of mental health practitioners* barrier by

discussing the mismatch in the number of patients he would like to refer and the number of providers:

> I think even in the last many five to ten years even getting someone to the city has improved some. There are a lot of people on both sides that realize there are problems and they're trying to fix these problems. The biggest problem is that almost every one of my patients that I see everyday has some sort of mental health issue to some degree and the ones that have a severe problem there is even too many of those for the amount of providers that we have.

Another RPCP, Dr. C, elaborated on the *scarcity of providers* and the difficulty that people have on traveling to see providers several hours away.

> Well, I think first off, there is a major shortage of mental health professionals period. I think I can count on two hands people that I know of in the areas specifically psychologists or psychiatrists that necessarily associated with our local mental health clinic. … The bottom line is that if they can't see people that are in the area, then there aren't a lot of options. There is a medical University that is 3-4 hours away and sometimes that is the only other option.

> Due to the *scarcity of providers*, patients in rural communities are forced to travel to surrounding communities minutes or hours away, causing them to encounter another barrier *cost of mental health care*. Dr. L elaborated on the financial strain that traveling has on families in rural areas and how availability hinders her ability to provide referrals:

> There's a big difference between how many [referrals] I would make and how many I would like to make. That was a real issue. I would make a whole lot more you're just so restricted by what you have available to you and

unfortunately so many families aren't able to drive that hour or can't take that time off work. In a lot of these situations that parents are single and to get their children to go to that counselor, or psychologist, or psychiatrist, it's really, really challenging so those are some of the limitations.

Cost of mental health care is another barrier that prevents RPCPs from being able to provide the referrals that they would like to make. The cost of traveling is sometimes prohibitive for families, in addition, to the cost for counseling services when local providers are not on insurance panels. Dr. I commented on the lack of Medicaid providers in her area, "well unfortunately we have one therapist and I think she is fantastic and she's not seeing Medicaid patients." Dr. E discussed the efforts that she extends to call the providers directly to find out what insurances they take before referring clients because if she does not, "they will say, 'I can't afford this,' and I will say, 'you can, because your insurance will cover it as long as you don't mind paying an upfront cost.'''' Dr. K summarized the RPCPs' consideration of cost:

> That's the thing about our town though, there was one person in town that I thought was good so if they weren't covered by insurance then they would have to drive so you are already asking them to go see a psychologist and pay for it and then they have to drive.

The *cost of mental health care services* is directly related to another barrier that often prevents the success of a counseling referral, *patient compliance*. Dr. G expressed the frustration that the RPCPs had with parents who failed to comply with counseling referrals for their children:

Part of it is parent delay, that's one of the significant barriers, is the parent failing

to comply with the appointment times and that's often a barrier that we cannot do

anything about unless we go to court. In general if it's not a major concern then

there aren't a lot of things you can do to make a parent do what you want them to

do and so if they fail then it delays the process more.

Another RPCP, Dr. H, went on to discuss how *patient non-compliance* and limited

resources can further limit the availability of treatment options when patients are ready to

comply:

Yes, and they will come back here when they don't feel like anybody else is

making any difference with something and it sort of pushes our limits as far as

what we are comfortable with. Because sometimes because you listen, you know

they need help, but then they have blown off my other health professionals. Or

they have burned a bridge there as far as not showing up or something.

All of the RPCPs in the study discussed the *importance of receiving feedback*

from the mental health practitioners. However, good feedback most often occurred when

a personal or professional relationship existed with the mental health practitioner. Dr. I's

description of this process illustrates the common disparity of receiving feedback from

providers she has a relationship with and receiving little feedback from providers with

whom she does not have a relationship:

So I have excellent feedback from [the therapist I know well] so it helps having

her [nearby] because when we run into each other. I get a letter back from her on

every patient she has seen or doesn't see. I get this patient was a no-show or this

patient shows, but that's the difference too, because those people I give her the

names and then she'll tell me that patient, I never did get them scheduled for an

appointment or this person scheduled an appointment but didn't show up. I

always get some good follow up from her. From the community, no, I don't

usually get a very good response. I almost never get any documentation back

from them….

 As Dr. I discusses, most often a follow-up was scheduled as the primary, or only, method

of feedback. The barriers are pervasive in the process; however, the RPCPs in the study

described working very hard to minimize the impact of these barriers in order to provide

their patients with the most comprehensive patient care.

Phase III: Following patient presentation. The third phase of the *Counseling*

Referral Evolution is the shortest of the three and consists of scheduling a follow-up and

the outcome of the patient. The third phase occurs after the RPCPs' consultation with the

patient and provision of a counseling referral, Phase II. Because the study was aimed to

understand the process of providing counseling referrals and the barriers inherent in the

process not much information regarding outcome emerged from the data.

Schedule follow-up. The scheduling of follow-up appointments for any patient

who was referred to counseling emerged as an important component in the process. Each

patient who is provided a counseling referral was also scheduled for a follow-up

appointment with the PCP. This process was true across all twelve participants. The

barriers inherent in Stage II warrant the scheduling of a follow-up. Most often this

appointment was used to determine if a patient had followed through with the referral due

to the absence of quality feedback from the mental health practitioners. RPCPs rely on

the patients' self-report about the quality and nature of their work with the mental health

practitioner in the absence of a better alternative. Due to the issues with the referral system and quality feedback from mental health practitioners, the RPCPs all scheduled these appointments as Dr. G described:

> What I do when I refer to counseling, is I set up a follow-up appointment in a month. Sooner if it's a big concern, but in general a month. And when they come back we make sure that yes, they've established contact with a counselor and psychiatrist if they need to and find out what medication they are on so that we can close the loop. Because if we don't get the feedback from the counselor then we don't really know so I try to get it back from the family.

Dr. L further described the process of setting up a follow up visit with the family in order to see if the therapy has been beneficial or not.

> No, usually what it would be is I would see them in follow up. 'How's counseling going?' That's usually the question and parents would say, 'You know it isn't doing very much, we don't see any difference,' or, 'we think it's great and it's been really helpful.' So it would be more of me of asking a question to talk about it during a follow up with me.

Due to the difficulties communicating with psychologists when relationships are not established, follow-up visits are the primary method of RPCPs knowing whether or not their patients have complied with recommendations. Some RPCPs discussed providing additional incentives to their patients to follow through with counseling recommendations by requiring that patients attend counseling prior to receiving refills on their prescriptions at the follow-up appointments as Dr. B described:

Well, I guess the biggest incentive I have to them, is that I might start the patient

on an antidepressant, but I am making this referral and in the next month you need

to follow through with your appointment with this counselor. Then if that doesn't

happen, I am not refilling this and then they need to come back and see me and

explain to me why that hasn't worked out, or they are not getting their

medications. Now there are cases of where it would be dangerous to not keep

someone on their medications. So in rare exceptions, that does not happen. But

prescription refills are certainly a good way to remind patients that, you know,

hey you are not upholding your end of the bargain.

The follow up appointment is the main method of the physician gaining an understand of

the outcome of both the referral and the mental health complaint.

Outcome. As previously stated, the Outcome emerged as a category, albeit not as

strong, but was included in the model for illustrative purposes. This category is the last

component of the *Counseling Referral* Evolution. The Outcome of the referral process is

characterized by patients' experiences in counseling and RPCPs' success in treating the

mental health concern.

According to the RPCPs, the majority of patients who accepted referrals reported

having a positive experience.   However, when patients reported negative experiences,

the RPCPs talked with the patients to understand the problems and find additional

methods encouraging the patient to get mental health care as Dr. J illustrated:

Well, generally when they come back, I think, eight out of ten people will tell me

that it really helped and they really felt like that was the thing to do and it changed

many aspects of their lives. I feel like maybe the 2 people out of 10 that maybe

don't feel like it made much of a difference were the ones that were probably a

little less honest at the appointment just because, I don't know if I should say less

honest but, the ones that are more resistant to go see a mental health specialist….

I see miraculous improvement in kids from counseling all the time and no

intervention from medicine.

RPCPs identified the way in which patient outcome continually informs their future

counseling referral practices when good outcomes are obtained. Dr. G illustrated this

process in her statement:

I would say my experiences with counselors in the field and friends who are

counselors and also just having positive outcomes of kids. I think that's probably

one of the most motivating factors is when you continue to see good outcomes

and that makes it more likely to do the same the next time. I think that also drives

why I use certain counselors because we see them do a good job with kids this

age.

Dr. C discussed the outcomes when medication alone, counseling alone, or medication

and counseling are used in combination.

When it comes to mental health issues, you can be successful 50% of the time

with medication or you can be successful 50% of the time with counseling, but if

you use it together, your chances of success are 90%. I think it's important to do

both. I have some friends that again, I can get feedback from, so that might affect

my decision to choose them more than somebody else. I think it's important, I

think counseling is just as important as medication.

Additionally, Dr. C stressed the importance of relationships improving feedback and increasing the likelihood of providing counseling referrals initially. He echoed the experience of the other RPCPs with his last sentence endorsing the, Midwestern RPCPs view of the importance of counseling.

      Areas for improvement. Several areas for improvement were identified by the RPCPs. Participants discussed changes that physicians and mental health practitioners could make to create improvements to the counseling referral process. Improvements included better communication, creation of a referral form, and continuing education focused on rural mental health care management.

      Improved communication between mental health practitioners and RPCPs in rural communities was identified by the RPCPs as one of the most important potential changes. Throughout the interviews, the RPCPs commonly identified methods in whey they could communicate better with their mental health care colleagues. The RPCPs readily identified their flaws and improvements that they need to make in reaching out to the area mental health practitioners; this was frankly discussed by Dr. A:

> I think the physicians have to be willing to give some time to meet [counselors] and understand what they're about and what they're going to be able to provide to you and your patients. I think that's probably the biggest thing that sometimes physicians are kind of standoffish when it comes to things like that.

One RPCP, Dr. J, elaborated on the importance of getting to know the providers better in order to work more efficiently and effectively together to treat her patients:

> I think that the one thing and I think that would be a change on both sides is the communication. I think that there needs to be a way where just like I can call the

ENT and get a report or something that we can do things like that with mental health professionals and you know, I think touching base with them on the phone would help the patient a lot even if they can't do paper records and I think from a doctor's perspective is time in the office. I think one of the problems of being in a primary care field is that it's a matter of taking the time and having the time to do your screening questions and really hash through is this patient really needing therapy is this patient really in danger or is this patient not. And most of the time there is but sometimes there's just too many people to see and you really wish that instead of making everyone wait for an hour so … that you could really be in direct contact with the psychologist or mental health personnel.

The *creation of a referral form* that Dr. J mentioned was another improvement mentioned by every physician in the study. A referral form that contained all of the relevant information about why the referral was made, to whom, when, and included a release of information emerged as an important document in all of the interviews; this was discussed by Dr. D:

Well I like pads of paper that have little tear off sheets that has the person's name on the top and then they list common diagnoses so it's a really quick that you just have to check it and referral and a spot for any additional information and then kind of along those lines….

When asked if the release of information could be added to the form she stated, " Yeah, [a form with the psychologists information, a check off list, and release of information] would be even better! That's brilliant!"

In addition to a referral form, the RPCPs requested additional feedback from mental health practitioners as stated above.

According to the RPCPs, *Continuing education* was the last essential component that needs improvement. In the first interview, Dr. H discussed the need for a community based collaborative mental health care continuing medical education (CME) designed to increase collaboration among mental health practitioners and RPCPs:

> … having a conference of both types of professionals, especially for a rural area. They are always looking for a good CME, and so if it came to the area, to provide that and to get all the players on their own and say, 'okay, how do we make your community work better in this regard?' So then people meet each other, they know faces and they know personalities and such and then you can exchange information. I think it would be pretty easy to generate that kind of buzz in the community. …Have that, then have a lunch discussion, and some examples of referral forms or whatnot and clinical encounter forms for us. Like, these are the questions that we wish you would ask.

All of the RPCPs agreed that a CME focusing on rural, collaborative mental health care would be beneficial to their work with patients. Dr. C's reaction to this idea nicely summarizes the responses of the RPCPs:

> I would think so. I would think that [a training designed for rural practitioners collaborating with one another, particularly with regards to mental health] would be very helpful. I certainly think that it would be very effective.

The RPCPs in the study all asked the researcher to contact them if she puts these ideas into action because they are "ready to attend."

Conclusions

The three phases of the *Counseling Referral Evolution* illustrate the process by which RPCPs practicing in Midwestern areas provide counseling referrals and respond to the mental health concerns of their patients. The training, experiences, and limitations inform the Perceived Mental Health Expertise of physicians, whereas their professional and personal Relationships with Mental Health Providers inform their understanding of the counseling process. Those concepts work together or separately to determine how the physicians work with patients who present with mental health issues. After issues were identified, physicians work to provide counseling referrals, but often encounter barriers that hinder their success at providing these referrals. Due to the limited feedback that RPCPs receive from mental health practitioners with whom they do not have relationships, follow-up appointments are scheduled to determine if the referral worked as intended and to gain an understanding of the outcome. Improvements to communication and collaboration in the form of personal communication, referral forms, and community based CMEs were identified as possible improvements to the process.

Chapter 5: Discussion

This chapter will present the implications of the results presented in Chapter 4. The chapter will begin by discussing the significant findings of the analyses and by providing possible explanations of the findings through their convergence or divergence with previous literature. Next theoretical, research, and practice implications will be discussed. Finally, limitations of the study will be presented along with suggestions for future directions for collaborative mental health care practices will be provided.

Findings

The findings of this study contribute to the scientific literature in the area of theory development, specifically understanding the process that Midwestern, RPCPs engage in when providing patients with counseling referrals. Insight into the associated factors and barriers which facilitate or hinder the *Counseling Referral Evolution* was also developed. Additionally, the suggestions provided by the RPCPs inform future directions regarding both research and practice.

Collaboration between primary care physicians and mental health practitioners has been explored in many articles and professional organizations have been advocating collaboration for years (American Association of Family Practice, 1995; Backus, 1952; Bibace & Walsh, 1979; Dym & Berman, 1986; Hepworth & Jackson, 1985; Prince et al., 2007; Sumerall, Oehlert, & Trent, 1995). Primary care doctors in rural areas are often the only recipients of mental health care complaints. Without relationships with mental health providers to assist in the treatment of these patients, primary care doctors are left only with pharmacological interventions earning them the label "de facto mental health care system in the United States" (Reiger, Goldberg, & Taube, 1978). While many forms

of collaboration exist, the traditional referral to counseling is the most common form of collaboration and typically involves the physician sending the patient to the psychologist for management of a problem (McDaniel, 1995). Previous research has illuminated numerous barriers commonly engrained in the referral system (Barsa, Toner, Gurland, & Latigua, 1986; Bray, Enright, & Rogers, 1997; Clark, Linville, & Rosen, 2009; Crane, 1986; Freeling & Kissel, 1988; Kainz, 2002; Koening, 2007; Kushner, Diamond, Beasley, Mundt, Plane, & Robbins, 2001; Marvel, Doherty, & Baird, 1993; McDaniel, 1995; McElheran, Eaton, Rupcich, Basinger, & Johnson, 2004; Miller, Hall, & Hunley, 2004; Pereira & Smith, 2004; Tai-Seale, McGuire, Colenda, Rosen, & Cook, 2007), as well as the benefits to patients when referrals are provided and followed (Barsa, Toner, Gurland, & Lantigua, 1986; Bray & Rogers, 1995; Bryan, Neal-Walden, Corso, & Rudd, 2009; Enright & Blue, 1989; Katon et al., 2002; Knight & Houseman, 2008; Koening, 2006; Lang, Norman, & Casmar, 2006; Luoma, Pearson, & Martin, 2002; Roy-Byrne et al., 2005; Segal, Kennedy, & Cohen, 2001; Unutzer et al., 2002).

Despite the known benefits of collaboration and the challenges inherent in the referral process, few studies have attempted to clarify the counseling referral process. The majority of the studies examining the referral process have taken place in the United Kingdom (Herrington, Baker, Gibson, & Golden, 2003; Knight, 2003), presenting complications in applying to the United States medical system. In the United States, studies looking at collaboration have provided evidence that positive personal or professional relationships between PCPs and mental health practitioners increase the likelihood of positive collaboration experiences (Denelsky, 1996; Kravitz et al., 2006; Miller, Hall, & Hunley, 2004; Pereira & Smith, 2004). The current study extends the

research by providing an in-depth understanding of the counseling referral process along with the inherent factors and barriers.

Interpretation of the model. The development of the *Counseling Referral Evolution* allows a better understanding of the process that RPCPs engage in when providing counseling referrals. It is evident from the emergence of the model that the referral process begins long before a patient is evaluated by a RPCP. Theoretically the referral process begins during the physician's training in medical school and continues through residency, while meeting and establishing relationships (professional and/or personal) with mental health practitioners, and when developing an understanding of counseling. These experiences, in isolation or harmony, inform the counseling referral practice when an actual patient does present for treatment with the RPCP. In cases where relationships with mental health practitioners have not been formed, providing counseling referrals is increasingly difficult for the RPCP. As well, many barriers emerge after the patient presents to counseling to complicate the process. Costs of mental health care, availability of providers, and patient non-compliance can impede the referral process and prevent patients from getting the care that they need. RPCPs then schedule follow-up appointments in order to determine if patients have met with mental health practitioners and to assess progress, particularly when mental health practitioners fail to follow up with the referring RPCP. And finally, patients either schedule and attend the referral appointments or encounter barriers that prevent them from getting the mental health care they need.

Several improvements could potentially serve as facilitators throughout the *Counseling Referral Evolution* while also eliminating barriers. Improved communication

between RPCPs and mental health practitioners would likely be facilitative of building

relationships and knowledge of counseling, allowing the process to flow more efficiently.

Additionally, continuing medical education units (CMEs) focused on primary mental

health care in rural areas surfaced as a potential catalyst for increased collaboration

between RPCPs and mental health care practitioners. Ideally, these continuing education

seminars would take place in the community and would serve to increase communication,

inform collaboration, and foster relationships between community providers. The RPCPs

in the study also unanimously discussed the need for a universal referral form that would

allow them to provide information about the counseling referral and enable the exchange

of information between providers by incorporating a release of information.

   Perceived mental health expertise of physicians. Perceived Mental Health

Expertise of Physicians is the category in Phase I of the *Counseling Referral Evolution.*

This category takes into account all of the information a RPCP has gleaned from medical

school, residency, and life experiences regarding mental health. Specifically properties

such as experience treating mental health problems, RPCPs' knowledge of standard of

care, RPCPs' training in mental health care, and RPCP's awareness of limitations in

treating mental health concerns emerged from this category.

   Previous research has called for changed in medical education and training to

incorporate improvements to patient interviews, knowledge of mental health concerns,

and collaboration with mental health practitioners (Anderson & Lovejoy, 2000; AMSA,

2009; ACGME, 2007; Bluestein & Cubie, 2009; California Senate Bill 983, 1998; Ireton,

Racer, & Hafner, 1978; Pereira & Smith, 2004; Twilling, Sockell, & Sommers, 2000).

Due to these calls-to-action and the range of time since the RPCPs in the study attended

medical school and residency (i.e., from 4 years to over 20 years since graduation from

medical school), variance in training programs appeared likely. Particularly, it would be

expected that changes within the training curriculum would have been reflected by the

participants based on calls to action for better training and increased collaboration

between PCPs and mental health practitioners (American Association of Family Practice,

1995; Backus, 1952; Bibace & Walsh, 1979; Dym & Berman, 1986; Hepworth &

Jackson, 1985; Prince et al., 2007; Sumerall, Oehlert, & Trent, 1995). However, RPCPs

in the current study discussed receiving little to no training in mental health care in

medical school and very few practitioners felt that their training during residency was

sufficient or helpful. Pidano, Kimmelblatt, and Neace (2011) conducted a study in which

they surveyed primary practice physicians' (i.e., pediatricians and family practice

physicians) comfort in assessing and treating mental health concerns in pediatric patients,

and found that 76% of the physicians endorsed interest in additional training related to

pediatric behavioral health. They also found that physicians were significantly more

comfortable assessing mental health concerns than treating those concerns. Additionally,

the primary care physicians in the study indicated that they would refer the majority of

patients who presented with any type of mental health problem to counseling, consistent

with the current study's findings (Pidano, Kimmelblatt, & Neace, 2011). The *Counseling*

Referral Evolution also provided insight into the influence of relationships with mental

health practitioners on RPCPs' perceived mental health expertise.

   Relationships with mental health practitioners. Relationships with Mental

Health Practitioners is the second category of Phase I and one of the most important

categories in the entire *Counseling Referral Evolution.* Previous literature has

demonstrated the link between personal and professional relationships between RPCPs

and mental health practitioners and effective collaborative mental health practice

(Denelsky, 1996; Kravitz et al., 2006; Miller, Hall, & Hunley, 2004; Pereira & Smith,

2004). Relationships in the current study appear to not only serve as a crucial category in

the model, but almost as facilitators of the referral process. Poor or limited relationships

between RPCPs and mental health practitioners appeared to increase the influence of

barriers into the *Counseling Referral Process.*

RPCPs identified strong working relationships with psychologists and mental

health care providers whom they have a relationship, as deemed important in previous

research (Denelsky, 1996; Kravitz et al., 2006; Miller, Hall, & Hunley, 2004; Pereira &

Smith, 2004). RPCPs discussed the continuous collaboration of and back-and-forth

communication, similar to Holloway and David's (2005) description of co-provision of

care. Co-provision of care occurs when the psychologist and the physician are

collaborating while simultaneously caring for the patient (Holloway & David, 2005).

Examples of co-provision of care were also found in the current study. For example, Dr.

L's description of her work exemplifies co-provision of care:

> I really rely on those individuals, so yeah, the more that they're connecting with
>
> me through paper or a phone call. He was wonderful calling the office and
>
> saying, 'can you have Dr. L call me at the end of the day? I want to talk to her
>
> about a referral I saw.' And actually the other thing, what was really helpful too
>
> when I would refer people to him, I would call him. Because I just knew him
>
> after taking care of his kids, so I would just call him. 'I'm sending you someone

this is his story, I will write you further details in a letter,' because I would usually send my notes that had a lot of details, or a letter, too. But I would actually pick up the phone for him, 'this is why this kid is coming to see you.' Now I know that's not going to happen all the time because you know people. But that was really nice and it just gave him a heads up on what to be thinking about. … It's really nice. It's such a nice thing. I just saw a girl yesterday who clearly needs counseling and I feel so much better to be able to say, "I have somebody for you." And I know they're going to be able to spend the time it takes.

Similarly to *co-provision of care* Doherty, McDaniel, and Baird (1996) defined five levels of collaborative interactions between RPCPs and mental health practitioners from *minimal collaboration* to *close collaboration in a fully integrated system*. The current study found relationships to be an important component of these five classifications. Participants in the current study interacted in the *minimal collaboration* stage only when barriers prevented them from being able to communicate with mental health practitioners (e.g., availability of providers, time restrictions, lack of knowledge about area providers). The improvements discussed by the RPCPs (e.g., referral form, meeting area providers) would facilitate a relatively easy transition to a higher level of collaboration. The majority of the providers in the current study most frequently used the second level of collaboration, *basic collaboration at a distance*, where they regard each other as resources and interact frequently about mutual patients by phone or letter while practicing independently. Whereas exclusion criteria prevented RPCPs who work in integrated practices from participating in the study, several of the RPCPs collaborate

utilizing the third stage, *basic collaboration on site*, only because in the rural

communities in which they practice the health care offices were in close proximity (i.e.,

on separate floors in the same building or across the street from one another). Exclusion

criteria prevented participants in the fourth or fifth levels of collaboration from

participating in the current research. Unfortunately, few Midwestern, rural communities

have integrated primary care practices making interoffice collaboration a necessity.

Therefore level three collaboration, *basic collaboration on site,* may be the most effective

level for Midwestern, RPCPs and mental health practitioners to utilize in their care of

patients, due to the limited number of providers and the financial challenges inherent in

the physical integration of offices.

The findings from a study conducted by Denelsky (1996) to better understand the

referral process and ongoing interactions between physicians and psychologists

corroborate the importance of the interpersonal relationship between RPCPs and mental

health practitioners in the referral process. Denelsky concluded that physicians who had

informal, friendly interactions with psychologists were more likely to respect

psychologists and to provide patients with referrals to seek treatment with them. Further,

Denelsky concluded that mental health practitioners who provided physicians with

updates, assessments, and a plan of care were viewed more favorably by the physicians.

The RPCPs in the current study discussed the importance of their relationships with the

mental health practitioners and the need for feedback from the providers to whom they

are referring. Pidano, Kimmelblatt, and Neace (2011) found that 85.4% of the primary

care physicians in their study would like to have a formal relationship with a mental

health provider, while only 60.4% endorsed wanting to have a mental health provider

onsite. The current study further validates the importance and need in establishing relationships with mental health practitioners.

In addition to relationships with therapists, several of the physicians in the current study discussed their own personal experiences in therapy. All of the RPCPs who discussed attending individual or couple's counseling stated that their experiences were positive and that they increase their likelihood to provide referrals to their patients. Crane (1986) concluded that personal experiences can lead to poor opinions of mental health practitioners. However, in the current study all of the participants who reported personal experiences in therapy described them positively. It is possible that RPCPs with negative experiences in therapy may have poor opinions of mental health practitioners impacting their counseling referral process in counterproductive ways. Kravitz et al. (2006) also found that personal experience with psychotherapy made physicians more likely to refer standardized patients portraying a person with a mental health concern. The results of the current study provide further evidence that the relationship is a crucial component of the collaborative process. In the *Counseling Referral Evolution*, Relationships with Mental Health Practitioners is one of the most important categories. It works to inform both a deeper understanding of counseling and limiting the inclusion of barriers into the model.

Understanding of Counseling. When positive relationships between RPCPs and mental health practitioners exist a deeper understanding of counseling is created and collaboration occurs organically. Conversely, barriers emerge when RPCPs fail to have relationships with mental health practitioners making it increasingly difficult to meet the needs of their patients. Similarly to Kainz (2002) conclusions, RCPCs in the current

study discussed learning about counseling through their relationships with mental health practitioners rather than through their education and professional experiences. This finding emphasizes the importance of creating collaborative relationships as a learning technique.

Barriers. In the current *Counseling Process Evolution,* Barriers present complications during each phase of the process. During Phase I, a lack of relationships with mental health practitioners hinder RPCPs' understanding of counseling (Bray, Enright, & Rogers, 1997; Crane, 1986; McDaniel, 1995). Without an understanding of the counseling process and the work that mental health practitioners engage in RPCPs are forced to rely on the limited training they receive in mental health care throughout medical school and residency (Anderson & Lovejoy, 2000; AMSA, 2009; ACGME, 2007; Bluestein & Cubie, 2009; California Senate Bill 983, 1998; Ireton, Racer, & Hafner, 1978; Twilling, Sockell, & Sommers, 2000).

During Phase II, Barriers such as time limitations (Marvel, Doherty, & Baird, 1993; Miller, Hall, & Hunley, 2004; Koening, 2007; Pereira & Smith, 2004), shortage of providers (Clark, Linville, & Rosen, 2009), cost of mental health care (Crane, 1986; Freeling & Kissel, 1988; Kushner, Diamond, Beasley, Mundt, Plane, & Robbins, 2001), and patient non-compliance (McElheran, Eaton, Rupcich, Basinger, & Johnson, 2004) serve as obstacles in the referral process. The lack of providers or limited availability of providers specifically in rural areas has been well documented in the literature. For example, Holzer, Goldsmith, and Ciarlo (1998) concluded that there is a significant shortage of psychiatrists in rural areas, specifically those with populations between 2,500 and 20,000. A shortage of psychiatrists in rural areas further supports the need for

primary care physicians and mental health practitioners to work collaboratively to provide mental health services to those in need.

Smalley, Yancey, Warren, Naufel, Ryan and Pugh (2010) conducted a review of the literature on rural mental health and psychological treatment, and concluded that the state of mental health in rural areas is defined by the shortage and acceptability of mental health services. They discussed the difficulty of scheduling a counseling appointment once a referral is made and the inconvenience of traveling for hours to the nearest available providers. They concluded that psychologists and physicians need to improve the referral process and be advocates for mental health care in their communities (Smalley et al., 2010). The *Counseling Referral Evolution* provides further understanding of the impact of the barriers on the referral process and the foreseen impact that improved relationships and collaboration could have on the process, particularly within rural communities.

Glasser, Vogels, and Gravdal (2009) examined the geriatric depression assessment trends among rural primary care physicians in Illinois. They concluded that although the RPCPs reported that more than 33% of their patients presented with mental health concerns, the care they would like to provide their patients was incongruent with the care available in their communities. Although 96% of the RPCPs thought that psychotherapy would be beneficial to their patients struggling with depression, they were confronted with severe barriers to treatment including cost of mental health treatment, lack of available providers, and patient non-compliance as the three most common barriers to treatment.

Improvements. The RPCPs in the study believed strongly that positive changes could be implemented on behalf of physicians and mental health practitioners to improve the counseling referral process. In fact, despite this issue being one of the latter components of the semi-structured interview, many of the physicians began discussing potential improvements after the very first question. In observing the RPCPs during the interviews, it was quite apparent that they were hopeful, enthusiastic, and thoughtful about these potential improvements frequently referencing situations with patients where these enhancements would allow them to better provide for their patients' mental health care needs. Additionally, all the RPCPs thanked the investigator for conducting this research and spoke of looking forward to learning about the results and future directions. The majority of the suggested improvements focus on establishing collaborative relationships between RPCPs and mental health practitioners. Additionally, more concrete methods of creating these collaborative relationships were discussed. The RPCPs indicated that referral forms and continuing medical education seminars focusing on rural community mental health would likely improve their counseling referral practice and enable citizens in rural communities to receive better mental health care.

Improved collaboration. The need for positive changes in the collaboration between primary care physicians and mental health practitioners has been well established in the literature (American Association of Family Practice, 1995; Backus, 1952; Bibace & Walsh, 1979; Dym & Berman, 1986; Hepworth & Jackson, 1985; Prince et al., 2007; Sumerall, Oehlert, & Trent, 1995). The current study serves to better understand the need for change and to begin developing improvements based on RPCPs suggestions. Specifically, enhanced communication between RPCPs and mental health

practitioners could allow them to provide better health care to their patients and work in harmony. Kapalka's (2009) study examining collaboration between pediatricians and psychologists corroborated the importance in improving the relationships between primary care physicians and mental health practitioners. Specifically, they discussed the need for psychologists to provide referring physicians with feedback about the assessment, diagnosis, and recommended treatment of patients whom the physicians had referred. They presented an ideal model of this form of collaboration, *the consultative relationship,* in which psychologists and pediatricians communicate with one another routinely regarding patient treatment plans, patient progress, and concerns (Kapalka, 2009). The RPCPs in the current study expressed specific interest in developing consultative relationships with mental health practitioners. RPCPs found consultative relationships to be personally and professional rewarding.

Furthermore, the RPCPs in the current study believed that improvements in the communication process and referral system between RPCPs and mental health practitioners would reduce the influence of barriers in the *Counseling Referral Evolution.* Similarly, the RPCPs in the Glasser, Vogels, and Gravdal (2009) study, concluded that better availability of providers, more time to spend with patients, improved patient compliance, and lower costs associated with mental health treatment would vastly improve their ability to treat patients' mental health complaints, specifically depression.

Creation of a referral form. RPCPs hypothesized that a referral form which includes relevant patient history, a check-list of symptoms, contact information and directions to the mental health practitioner, along with a release of information would allow for more communication and greater ease in referrals between physicians and

mental health practitioners. They also discussed this process being helpful for mental

health practitioners in that patients would present with a brief history and collaboration

with the RPCP could be immediately established. RPCPs were acutely aware of the

imposition that referrals without accompanying documentation provide for mental health

practitioners. They hypothesized that this challenge would be more cumbersome in rural

areas where the few available providers are inundated with patients.

 Continuing medical education. Additionally, continuing medical education

seminars focused on rural community mental health were identified as a good mechanism

to introduce RPCPS and mental health practitioners to one another and to allow them to

problem solve community issues in one place. RPCPs discussed their own reluctance and

need to reach out to the community providers to begin establishing relationships. The

RPCPs in this sample who have reached out to mental health practitioners in the

community discussed its importance to their referral process. It is likely that these

suggested improvements would create a more efficient model of collaboration and mental

health care in rural areas; however, further research is needed to verify the influence of

these potential improvements.

Theoretical Implications

 Previous research has failed to provide a comprehensive understanding of the

counseling referral process for any PCPs, much less RPCPs, though previous researchers

have developed models illustrating the counseling referral process. A study conducted in

the United Kingdom by Herrington, Baker, Gibson, and Golden (2003) created a three

part model for physicians counseling referral process. Their model included patient

consultation with their PCP, negotiation between the PCP and the patient, and choice of

referral by the physician. The *Counseling Referral Evolution* confirms their model and also provides further explanation.

The current model expands on Herrington et al.'s counseling referral model by including precipitating events and information that informs the physician's consultation with the patient. Barriers that impede the process are also included in the model along with the importance of being familiar and having professional relationships with the mental health practitioners in the community. Another study conducted in the UK determined that the availability of mental health services and physicians' perceived expertise in psychological health impacted physicians' decisions to provide referrals (Knight, 2003). Knight also found the doctor-patient relationship to be a factor in the referral decision. Conversely, several of the physicians in the current study discussed their relationships with their patients as being important, but not necessarily impactful in their referral decision. Regardless of the relationship with the patient, all of the RPCPs in the current study discussed the importance of counseling and the use of counseling with their patients. Rural culture may be a factor that distinguishes the RPCPs' practice of referring new and long-term patients from the RPCPs in Knight's study. In rural communities, RPCPs are often the first and only place where patients present with mental health concerns. Therefore, RPCPs are in a unique position to provide patients with referrals to local community or distant mental health providers.

As one physician in the study commented, "Oh absolutely, we had a med student here the other day that said, 'Man, you don't see any psych problems,' and I said, 'Are you kidding me, we see nothing but psych problems'." Though this statement was made jokingly it illustrates that common occurrence of patients presenting with mental health

concerns in rural communities. This physician and other RPCPs in the study discussed

the incidence of mental health concerns in the majority of patient visits. Although the

study did not gather quantitative data on the diagnoses given to patients, situational mood

disorders in adults and behavioral problems in children emerged as their patients most

common mental health concerns. Dr. B discussed the occurrence of situational mood

disorders along with the responsibility she feels to treat them:

> I feel like [situational mood disorders are] more prevalent in a rural community, it
>
> seems like their issues, for example, an elderly patient may be caring for an ill
>
> spouse at home, or maybe it is a farmer who hasn't seen a doctor in 10 years, or a
>
> young mother without any outlet or support system for other caregivers for her
>
> children. Those things are all risk factors for problems with anxiety and
>
> depression and I think a lot of times those people just don't know of any support
>
> systems in place, so their primary care physician, their family doctor, becomes the
>
> first place that they ever talk to anyone about that.

Physicians in rural communities often have the awareness that if they do not provide

counseling referrals, patients will most likely not seek counseling services independently;

this factor may be different for patients in more urban areas where counseling services

are widely advertised and available.

With this new understanding of the *Counseling Referral Evolution* efforts can be

concentrated on assisting mental health professionals and primary care physicians

practicing in rural, Midwestern communities to develop collaborative relationships with

one another in order to improve the referral process and overall collaboration. While

previous research has provided consistent support of the need for collaboration (Prince et

al., 2007), there has been little research designed to provide an in-depth understanding of the referral process and the problems inherent in the process. With this more developed explanation of the referral process, RPCPs and mental health practitioners can end the "blame game" and work together to facilitate improvements in the referral process. This study provides implications for both research and practice in incorporating the importance of collaboration between RPCPs and mental health practitioners.

Research Implications

In addition to benefitting RPCPs and mental health practitioners, and in turn, benefiting patients, researchers now have a more defined model to further study. Future research is necessary to determine if the improvements discussed by the physicians would truly impact the model as anticipated. In addition to the perspectives from RPCPs this issue should be examined from the perspective of mental health providers. Researchers could replicate this study with rural mental health providers to further understand their experience of physician referrals. It is possible that the process may be viewed differently from the perspective of mental health practitioners. If so, there are potential barriers that need to be addressed and the perspectives of mental health practitioners could inform a more clearly defined model. Additionally, due to the homogeneity of the current participants, the study could be replicated in different geographical areas, urban areas, and suburban areas to determine if the process of providing counseling referrals is different based on geographical or population factors.

Future research reviewing existing charts at medical clinics should be conducted to further evaluate the variables that promote or hinder physician referral. A standardized referral form and system should be created for use in rural communities. Additionally,

research should be conducted on the benefit of implementing such a form evaluating changes in referral rates, follow-through, and collaboration.

Additionally, medical school trainings in collaborative mental health care should be developed, standardized, and evaluated. As well, research to determine the best method of establishing and maintaining professional relationships with mental health practitioners should be examined further. Furthermore, continuing medical education targeted toward rural primary mental health care should be established. Based on the suggestions of the participants of the current study, these trainings should take place in the local community and should include all of the physicians and mental health care providers in the area. Providers should be given opportunities to communicate with one another and establish preferred referral methods with one another. Opportunities for physicians and mental health providers to learn about each other's areas of specialty are also warranted.

Practice Implications

The current study serves to inform mental health care practices for mental health care practitioners and RPCPs. Providers in rural areas may utilize the *Counseling Referral Evolution* to problem solve which barriers are impacting their ability to provide efficient counseling referrals. For example, perhaps a lack of adequate training has prevented exposure to mental health practitioners thus limiting the physician's ability to develop an understanding of counseling and form relationships with mental health practitioners. By viewing the model, RPCPs may be able to identify in which category of the *Counseling Referral Evolution* barriers are being incorporated into their referral process, enabling them to take action to eliminate these barriers. Conversely, mental

health practitioners in rural communities may utilize the model in order to establish collaborative relationships with RPCPs. Providing RPCPs with materials about their practice and preferred methods of contact may help to facilitate open communication. Additionally, mental health practitioners may benefit from providing trainings to RPCPs on new mental health concerns impacting their communities. RPCPs and mental health practitioners may utilize the current study to create collaborative treatment teams to provide more adequate mental health care to patients with serious mental health concerns.

The *Counseling Referral Evolution* model specifically provides practical implications to the fields of Counseling Psychology and medicine. The purpose of the current study was to develop a deeper understanding of RPCPs' counseling referral practices so that improvements by both physicians and mental health practitioners can occur to better serve rural patients with mental health concerns. Mental health practitioners practicing in rural communities can initiate collaborative relationships with RPCPs in the area to build their practices and to enable more comprehensive and collaborative mental health care of their patients. Additionally, mental health practitioners can create referral forms and distribute them to area RPCPs as a method of forming connections and generating more referrals. Mental health practitioners may also seek employment or establish outreach clinics in rural areas to increase the availability of providers in small communities. Lastly, this study provides implications for RPCPs and mental health practitioners to advocate for funding and initiatives to create community partnerships in rural areas to meet the needs of millions of rural patients in the United States.

Additionally, this study provides framework to complement training initiatives in medical schools and mental health care training programs regarding the establishment of collaborative relationships. Presenting more information about the benefits of combined medical and psychological interventions may serve to provide an additional method of providing RPCPs with an understanding of the counseling process.

Furthermore, social justice (allowing rural patients to have the mental health care services they need) and advocacy for rural patients calls for intentional efforts to develop relationships with physicians on the part of mental health practitioners. The current study provides evidence that undertaking efforts to create relationships with RPCPs will likely be beneficial in providing rural patients with enhanced mental health care. Additionally, the current study exemplifies the desire of RPCPs to engage in collaborative relationships when barriers are minimized. Therefore, mental health practitioners should make every effort to create lasting relationships with RPCPs and provide rich, consistent feedback to referring physicians to improve the treatment of their patients.

Limitations

In all research, limitations are inherent and need to be examined to determine their impact on the findings and implications of the study. The two main sources of limitations in the current study are the methodology and the population sampled. Grounded theory was chosen as the study methodology to develop an understanding of the counseling referral process from RPCPs, allowing for a better understanding of all aspects of the process including limitations, preferences, and potential changes. In grounded theory research, the investigator takes the central role in data collection and analysis. Although efforts were taken to minimize researcher bias, it is possible that the researcher's biases

may have impacted the study. Additionally, because the qualitative research design was constructed by the researcher, future attempts to replicate this study with different participants and a different researcher may fail to yield the same results despite efforts taken by the researcher to remove bias and improve generalizability.

Another limitation concerns the population sample. Because the study was examining the counseling referral practices of Midwestern RPCPs certain limitations were inherent in the design. Traditionally, these physicians are very busy managing work life and community and family responsibilities. In order to accommodate the physicians in the study, interview time was gradually reduced from a 60-90 minute interview to a 30-60 minute interview. The researcher received feedback during the initial three interviews regarding the length of the interviews placing a hardship on participants. As such, attempts were made to reduce the hardship and still attain quality, rich interviews that allowed the counseling referral process to emerge. In order to provide these accommodations, several interviews were conducted via Skype with RPCPs in their homes and/or while traveling. Participants were informed that the interviews would take at least 30 minutes, but may require more time or a follow-up interview. Participants found it much easier to fit a 30 minute interview into their schedules rather than an hour-long interview. However, additional time in the interviews may have allowed for a better understanding of the counseling referral process. It is possible that additional categories may have emerged if additional time was provided. In an effort to deter the shortened interview from providing a misrepresentation of the referral process, several participants were shown the model after its completion and asked to clarify or provide additions. The physicians who responded all stated that the model represented their referral process and

provided no additions or clarifications. This information is useful for future studies in this area, because shortened interviews may provide better recruitment and participation in order to accommodate physicians, but could potentially interfere with the emergence of rich qualitative data.

Although grounded theory research allows for the rich understanding of processes to emerge, interview protocols may need to be shortened for this population to facilitate participation. Additionally, it seems probable that the time restriction was a likely reason that RPCPs who received recruitment information did not reply or agree to participate. Therefore, the current process may be skewed to include only those RPCPs who value collaboration with mental health professions and improvements to the referral process to agree to relinquish one to two hours of their time to participate in the study. The *Counseling Referral Evolution* process may look different for RPCPs who do not share the same value in collaboration with mental health practitioners.

Another accommodation provided to the physicians was the allowance of Skype interviews. Several of the physicians identified time limitations that prevented the researcher from being able to travel to interview the physician in-person. Conducting interviews via Skype prevented the researcher from observing the office conditions of the physician. Additionally, Skype interviews may have reduced the researcher's ability to establish rapport with the RPCPs. However, the themes of the referral process for the practitioners held constant regardless of the mode of interview.

Lastly, the researcher was identified as a mental health practitioner to the participants, potentially creating a bias in the respondents. It is possible that the RPCPs in the study may have tried to present themselves in the way they believe the researcher

would like to see. The researcher took precaution to minimize this reaction by clearly explaining the intent of the study and by also mentioning the researcher's unique position having both medical school training and mental health training. Participants appeared to respond candidly to the questions, but it is possible that they may have been attempting to favorably represent themselves.

Summary and Conclusions

Results of this study provide clarification to the research questions stated in Chapter 1, specifically, In what process do rural primary care physicians engage when making a referral to counseling?; and What factors influence referrals and collaboration between rural primary care physicians and psychologists? A grounded theory approach allowed the *Counseling Referral Evolution* to emerge from interviews with Midwestern RPCPs providing a rich, detailed process. This study provides insight into RPCPs process of providing counseling referrals to their patients and describes barriers that interfere in the successful collaboration between RPCPs and mental health practitioners. Detailed suggestions are also provided for improvements in the *Counseling Referral Evolution* generated by RPCPs. Based on the preceding discussion of the results, several conclusions were drawn from this study.

First, it appeared that the study achieved the primary goal of providing an in-depth understanding into RCPCs counseling referral process. The emergence of the *Counseling Referral Process* allows for mental health practitioners and RPCPs to understand the referral process along with facilitative factors and barriers. This understanding has important implications for theory, research, and practice. Secondly, relationships with mental health practitioners were facilitative of an increased

understanding of counseling and the lessened interference of barriers. This provides

critical implications for mental health practitioners and RPCPs to meet one another and

begin collaborating to improve mental health care for rural patients. Next, RPCPs in the

study identified several improvements that can be utilized by rural providers to make

improvements in the mental health care provided to their patients. Ideas for a

standardized referral form and community based collaborative mental health care

continuing education opportunities were presented. Lastly, several implications for

future research on collaborative mental health care in rural communities were provided.

This study provides a timely contribution to the area of collaborative mental health care.

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Appendix A: Summary of Participant Characteristics

	Dr. A	Dr. B	Dr. C	Dr. D	Dr. E	Dr. F	Dr. G	Dr. H	Dr. I	Dr. J	Dr. K	Dr. L
Demographics												
Gender (M/F)	M	F	M	F	F	F	F	M	F	F	M	F
Type of PCP Pediatrician(P) Family Practice Physician (FP)	FP	FP	FP	FP	P	P	P	P	P	P	P	P
Race (self-identified), Caucasian	C	C	C	C	C	C	C	C	C	C	C	C
Ethnicity American(A), Asian Indian (AI), Egyptian (E)	A	A	A	A	AI	A	A	A	A	E	A	A
Medical School Location Midwestern(M), Asian (A)	M	M	M	M	A	M	M	M	M	M	M	M
Location of Residency Training Midwestern(M), East Coast(E), West Coast (W)	M	M	E	W	M	M	M	M	M	W	M	M
Years in Practice in a Rural Area	13	2	5	1	1	3	2	4	2	1	3	12

Appendix B: Interview Guide

The Referral Process: Rural Primary Care Physicians' Perspectives on Providing Counseling Referrals

Qualitative Interview Questions:

1. What practices do you engage in when considering providing a counseling referral?
2. If you do decide to make a referral, how do you go about providing that referral?
3. Are there any personal or professional experiences that affect your decision to make counseling referrals?
> Prompts: Do you know any psychologists/mental health practitioners? How do you view or think about psychologists? How do you describe what a psychologist does? Are you more likely to refer to a psychologist, counselor, or social worker? Do past referral experiences affect your practice of making referrals?
4. What criteria do you use to determine who should be referred to counseling?
> Prompts: What types of patients receive referrals more frequently and less frequently than others? Are there differences in referrals for males versus females? Is your practice different for adults versus children? Has your practice changed at all since you've been in practice? How are counseling referrals similar or different to other types of referrals you make (i.e., to an ear, nose and throat specialist?)
5. How is a counseling referral made?
> Prompts: What symptoms need to be present? Does the patient have to agree to a referral? What steps do you take in the process? How is your office staff involved?
6. What barriers are involved in your referral process, if there are any?
> Prompts: How do you decide who to refer to? Ease of getting an appointment?
7. What happens after a referral is made?
> Prompts: Do you receive follow-up from the psychologists? How do you follow-up?
8. Are there any professional guidelines or training that impact your referral decision?
> Prompts: Are there professional standards or practices that govern your referral decisions? What training have you received on providing counseling referrals? What training have you received on mental health care management? Have you worked with a psychologist before?
9. How would you describe your relationship with mental health professionals?
> Prompts: Do you commonly refer or collaborate with any psychologists? Are you friends with any psychologists? How can psychologists benefit your practice?
10. Are there any changes that could be made by psychologists to make the process more efficient?
> Prompts: How could they make the process easier?
11. Are there any changes that could be made by physicians to make the process more efficient?
> Prompts: How could you make the process easier? Would additional training be helpful? Referral Form? Continuing Education?

Appendix C: Transcriptionist Confidentiality Agreement

Confidentiality Agreement

Transcription Services

I, _____, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Casey Tallent related to her research project: *The Referral Process: Rural Primary Care Physicians' Perspectives on Providing Counseling Referrals*. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Casey Tallent;

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;

4. To return all audiotapes and study-related documents to Casey Tallent in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) _____

Transcriber's signature _____

Date _____

UNIVERSITY OF NEBRASKA
Lincoln

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Educational Psychology

IRB# 20101210628 EX
Date Approved: 12/01/2010
Valid Until: 08/31/2011

The Referral Process: Rural Primary Care Physicians' Perspectives on
Providing Counseling Referr als

INFORMED CONSENT FORM

Purpose of the Research:
The purpose of this study is to construct a model that provides insight into the counseling referral process used by primary care physicians in the Midwest. The study seeks to understand and find strategies to improve the referral process and collaboration between primary care physicians and psychologists. Additionally, the study will explore the limitations inherent in the referral process.

Procedures:
You were selected to participate in this study because you were identified as a primary care physician practicing in a rural area. In order to participate, you must be at least 19 years of age. Your participation in this study will require approximately one to two hours of your time and you will be asked to: (a) participate in a face-to-face or Skype interview (b) provide detailed responses to the open-ended questions asked by the interviewer. Interviews will be audio taped and transcribed.

Risks and/or Discomforts:
Potential risks include feelings of discomfort associated with discussing professional practices; however, in order to minimize risks and increase participant comfort levels discussing the topic, a professional transcriptionist will be asked to sign a confidentiality agreement and transcripts will be labeled with pseudonyms and will not be linked to participants. Participants will be assured that their responses will in no way influence their relationships with colleagues or the researcher. Referrals to mental health care providers will be provided if needed.

Benefits:
The findings of this study will be used to provide insight into the referral process of physicians to counseling and to encourage collaboration between psychologists and primary care physicians. You may acquire final results of the study after August 30, 2011 by contacting the primary investigator, Casey Tallent, at caseytallent@yahoo.com.

Confidentiality:
You will be asked to identify your name in order to return the transcripts of your interview to you for your feedback. Information collected for this research study will be kept confidential. For confidentiality reasons, participants will choose a pseudonym that is not related to their legal name so that they can be assured anonymity. The pseudonyms will be used to label transcripts and notes. Only the consent form and master participant list will contain the participant's name. The master list containing the participant's name and pseudonym will be available only to the research investigator and will be destroyed on completion of data collection and analysis.

Please Initial Here:_____

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All of the audio and written materials will be kept in a locked cabinet accessible only to the principal researcher until the project is complete, which will be in 1 year. The information obtained in this study will be reported in a dissertation and may be published in scientific journals or presented at professional conferences, but only group data will be reported in order to ensure anonymity. A second round of pseudonyms will be given to participants by the researcher in order to further protect the identities of participants. Any quotes used in presentations or publications will identified by the second pseudonym. Additionally, if the participant's identification can be made through demographic characteristics, these characteristics will be changed for purposes of publication.

Compensation:
No compensation will be offered for this study.

Opportunity to Ask Questions:
You have the right to ask any questions pertaining to this research and have those questions answered before agreeing to participate or continuing participation in the study. You may call the researcher at (402) 613-7613 or e-mail caseytallent@yahoo.com with questions.

If you have any questions concerning your rights as a research participant that have not been answered by the investigator or to report any concerns about the study, you may contact the University of Nebraska-Lincoln Institutional Review Board, by phone at (402) 472-6965.

Freedom to Withdraw:
You have the right to decide not to participate in this study or to withdraw at any time during the study without affecting your relationship with the researcher or the University of Nebraska-Lincoln. You may refuse to answer any question you do not wish to answer. If you decide to withdraw after already providing data, you may request this data to be erased.

Consent, Right to Receive a Copy:
You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

THANK YOU FOR YOUR PARTICIPATION!

_____ Check if you agree to be audio taped during the interview

_____   _____
Signature of Research Participant   *Date*

You may contact the investigators at:

Casey N. Tallent, M.A.   M. Meghan Davidson, Ph.D.
Principal Investigator   Secondary Investigator
(402) 613-7613   (402) 472-1482
caseytallent@yahoo.com   Mdavidson2@unl.edu

University OF Nebraska Lincoln

July 6, 2011

At Casey Tallent's request I have completed an audit of her dissertation materials to determine if the themes, findings and interpretations of her research are supported by the data, and to confirm that the protocols established by the Institutional Review Board for the safety of the participants were followed.

After signing a confidentiality agreement I received a file that included hard copies of the interview transcripts with identifying information redacted; hard copies of the coding materials and model development notes; a thumb-drive containing the dissertation, Word files of the transcripts, and audio files of the interviews; the research journal; and the transcriptionists' confidentiality agreements. Before giving me the file Casey showed me the signed consent forms for all the participants and then returned them to a locked cabinet. Upon reviewing the materials I can confirm that the IRB protocols were followed explicitly.

The materials also demonstrate an outstanding application of qualitative research methods, specifically grounded theory. Casey openly reviewed her biases towards the research topic and requested that two participants review the model to determine if her biases had shaped it in any way that did not reflect the participants' perspectives. The participant reviews indicated that the model and all of its components were congruent with their counseling referral process. She used responsive interviewing to allow participants to guide the interview, and used quotes from multiple participants that provided a deeper, richer description of each theme. The participants' quotes were taken from the transcripts accurately and within the proper context, ensuring that the participants' voices were clearly heard.

Through the use of all stages of grounded theory analysis Casey has developed a model that describes the counseling referral process used by rural primary care physicians that reflects the perspectives of the physicians. It is my determination that the themes, findings and interpretations in this dissertation are fully supported by the data, and that Casey Tallent has created a model that will contribute to the development of collaborative mental health care in rural environments and beyond.

Janice M. Deeds, Ph.D.
Associate Director, Student Involvement
Director, Women's Center

Appendix F: Open Coding Scheme

Categories	Properties	Dimensions
Perceived Mental Health Expertise of Physicians	Awareness of limitations treating mental health concerns	High to Low
	Experience treating mental health concerns	Moderate to Low
	Knowledge of standard of care with regard to mental health	High to Moderate
	Training in mental health care	Moderate to Low
Relationship with Mental Health Providers	Individual experiences in counseling	Many to None
	Friends or family who are mental health providers	Many to Few
	Knowing providers in the community	Many to Few
	Nurses or partners who have relationships with providers in the community	Many to Few
Understanding of Counseling	Learn from personal/professional relationships with mental health professionals	High to Low
	Learn from partners	High to Low
Mental Health Complaint or Diagnosis	Severity	High to Low
	Age	Adult to Child
	Is counseling necessary or sufficient for the issue	High to Low
Referral Decision	Time of referral	Immediately to Distant
	Number of referrals provided	Several to One
Method of Referral	Discussion with the patient	Nurse to Doctor
	Who provides the actual referral to the patient	Nurse to Doctor
	Method of communication with the mental health practitioner	Direct to None
Follow-up Appointment	Schedule Follow-up Appointment	Always
Outcome	Response of Patients	Good to Bad
Barriers	Availability of providers	High to Low
	Cost of mental health care	High to Low
	Patient compliance	High to Low
	Value of feedback	High to Low

Appendix G: Axial Coding Scheme

(c) context

(a) causal conditions – (b) phenomenon – (d) intervening conditions – (e)

action/interaction strategies – (f) consequences

(a)   physicians' expertise, relationships with mental health providers, understanding of

counseling, mental health complaint

(b)   referral decision

(c)   high versus low awareness of limitations treating mental health concerns,

moderate versus low experience treating mental health concerns, high versus moderate

knowledge of standard of care with regard to mental health, moderate versus low training

in mental health care, many versus no individual experiences in counseling, many versus

few friends or family who are mental health providers, many versus few known providers

in the community, many versus few nurses or partners who have relationships with

providers in the community, high versus low knowledge of counseling from

personal/professional relationships with mental health professionals, high versus low

knowledge of counseling from partners, high versus low severity of complaint, adult

versus child age, high versus low need for counseling

(d)   lack of relationship with mental health professionals, availability of providers,

cost of mental health care, patient compliance, value of feedback

(e)   method of referral, schedule follow-up

(f)   outcome