Barriers to Mental Health Referral From Pediatric Primary Care Settings

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Objective: To examine the frequency of barriers to mental health referral according to pediatric primary care physician (PCP) report and to identify factors related to perceptions of referral barriers for patients with managed care coverage.

Design and Methods: Data from a national sample of 319 PCPs were examined. Comparisons were made concerning the frequency of PCP-reported barriers to mental health referrals for patients with fee-for-service versus managed care coverage. The relationship between relevant factors (eg, practice structure, interdisciplinary office staff, availability of community mental health resources) and perceived barriers was examined for managed care coverage.

Results: Barriers to mental heath referrals were more commonly reported for those with managed care versus fee-for-service coverage for 11 of the 12 barriers assessed ($P < .0001$). For patients with managed care coverage a high availability of community mental health resources was associated with fewer perceived barriers among physicians ($P < .0001$).

Conclusions: Our findings suggest that PCPs perceive barriers to mental health referrals as common challenges when addressing psychosocial concerns. Referral barriers were more commonly reported for patients with managed care coverage. Increasing the availability of community mental health resources was identified as an important variable in facilitating appropriate referrals.

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Psychosocial problems are common clinical challenges for primary care physicians (PCPs).[1,2] The estimated prevalence of diagnosable mental health concerns among school-age children presenting to primary care pediatricians ranges from 11% to 20%.[3] Identification of psychosocial distress by pediatric clinicians is an important factor in facilitating the delivery of mental health services.[4] Studies suggest that PCPs tend to feel responsible for identifying psychosocial problems, but often lack the knowledge, time, and confidence to respond adequately, underscoring the importance of mental health referrals.[5]

Psychosocial problems are underrecognized and inadequately addressed in the pediatric setting.[3,6] PCPs often lack the resources and training to adequately assess for behavioral disturbance within the primary care setting.[7] Furthermore, time constraints make it difficult to sufficiently assess and respond to psychosocial concerns. As a result, PCPs tend to demonstrate low sensitivity for detecting psychosocial concerns among primary care pediatric patients.[8,9]

Despite the challenges of addressing mental health concerns in primary care, the rate of clinician identification of psychosocial concerns among children has increased from 6.8% in 1979 to 18.7% in 1996, with attention problems showing the greatest absolute increase (from 1.4%-9.2%).[10] While this increased identification rate is promising, the positive impact depends largely on the accessibility of mental health resources when indicated.[11] Another important issue is the expanding prevalence of managed care and the introduction of behavioral health carve-outs.[12] The implementation of carve-outs, which separate mental health and general healthcare reimbursement structures and provider panels, may compromise the accessibility, quality, and continuity of mental health services.[13,14]

Empirical data examining referral patterns for mental health services from pediatric primary care are sparse. The adult literature suggests that referral patterns are important in patient satisfaction,[15] and demonstrates a complex relationship between insurance status and access to specialists.[16] A recent examination of the Child Behavior Study (CBS) dataset presented descriptive data on referral barriers, and noted some differences by insurance coverage.[17] The present study expanded the previous CBS analyses to examine the following:

- What is the frequency and content of barriers to mental health referrals according to PCP report?

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- Are there differences in the frequency of mental health referral barriers for patients with managed care compared to fee-for-service (FFS) coverage according to PCP report?
- How do physician, practice, and community characteristics relate to PCP perceptions of mental health referral barriers for managed care patients?

We expected that perceived barriers would be higher for patients with managed care coverage than for those with FFS coverage. Based on this hypothesis, we planned to conduct further analyses to examine predictors of referral barriers in managed care patients, in particular. The following factors were expected to relate to the presence of referral barriers for managed care coverage: practice structure, interdisciplinary office staff, and availability of mental health services in the community. Multispecialty practice groups and interdisciplinary office settings were expected to promote greater access to behavioral services, resulting in lower reports of referral barriers. Similarly, communities with mental health resources readily available were expected to be associated with lower reports referral barriers.

METHODS

Setting

Two large primary care research networks participated in the CBS: Pediatric Research in Office Settings (PROS; Elk Grove Village, Ill)[18] and Ambulatory Sentinel Practice Network (ASPN; Denver, Colo).[19] Additional family medicine participants came from the Wisconsin Research Network (WReN; Madison, Wis) and the Minnesota Academy of Family Physicians (MAFPRN; St. Paul, Minn), 2 regional networks with characteristics similar to ASPN. These networks include representation from clinician practices nationwide. To examine the representative nature of the sample, participating pediatricians were compared with a sample of members of the American Academy of Pediatrics (AAP) and were found to be comparable with regard to demographic and practice characteristics, although CBS participants noted more burdensome paperwork and less collaboration with other professionals compared with the AAP sample.[20]

Sample

A total of 539 clinicians agreed to participate and 431 clinicians returned the study measures, reflecting an 80% response rate. Data on characteristics of nonresponders were not available in order to conduct any comparisons, although the comparability between the sample and the AAP members supports the representative nature of the sample.[20] A total of 319 (74%) pediatric clinicians met criteria for the current analyses. In contrast to a previous examination of the CBS data,[17] clinicians in practices with less than a 10% managed care patient base (n = 99; 23%) were excluded in order to focus the analyses on practitioners with a sizable managed care patient base. In addition, surveys with 3 or more missing responses to questions related to perceived barriers (n = 13; 3%) were excluded.

Procedures

Procedures and consent forms were approved by institutional review boards affiliated with PROS, ASPN, and the University of Pittsburgh and have been described in detail elsewhere.[6]

Measures

Participating pediatric clinicians were asked to complete the Clinician Practice Questionnaire (CPQ), a self-report measure that was mailed to participants. The CPQ assesses clinician demographics, training, attitudes, and beliefs about psychosocial aspects of patient care, perceptions about insurance barriers to mental health referrals, and practice characteristics. The measure was developed and modified based on literature review, focus group discussions, and pilot testing.

Perceptions of Referral Barriers

In order to assess clinician perceptions of barriers to mental health referral, PCPs were asked to indicate whether or not 12 different factors limited their referrals. PCPs were asked to indicate the absence or presence of barriers separately for their FFS and managed care patient populations. Fee-for-service was described as private insurance with or without deductible, and managed care was defined as healthcare delivery through a health maintenance organization, preferred provider organization, or independent practice association. The list of potential barriers included lack of availability of certain pediatric specialists, financial disincentives, burdensome paperwork, difficulty/delay in getting an appointment, among other items. Responses were recorded as yes, no, or not applicable. The internal consistency reliability of the scale was adequate as measured by Cronbach's alpha (α =.77).

Clinician Characteristics

Demographic information (age and gender), training (discipline and completion of a mental health residency rotation or fellowship), and attitudes and beliefs about psychosocial aspects of patient care were assessed.

Practice Characteristics

Information about practice structure, the presence

of a mental health specialist at the practice, and the availability of child mental health resources in the community was obtained. Clinicians chose from a list of categories to describe practice structure, and were grouped as either multispecialty group practice or single-specialty practice (eg, solo practitioner, pediatric practice, and family medicine practice). A mental health specialist was considered present and the practice was categorized as interdisciplinary in nature if any of the following worked at the practice at least 1 day a week: behavioral/developmental pediatrician, psychiatric nurse clinician, social worker, psychologist, counselor/therapist, child psychiatrist or psychiatrist. The availability of child mental health resources was rated by participants on a 5-point Likert-type scale (1 = not available to 5 = very accessible). Responses were dichotomized as available and accessible (a rating of 4 or 5) versus all others. In addition, clinicians estimated the proportion of healthcare delivery modes for their practice (no insurance, Medicaid, private insurance, managed care, CHAMPUS, no charge).

Data Analysis

We employed descriptive statistics to examine the frequency and content of PCP perceptions of referral barriers to mental health services for pediatric patients. Bivariate analyses were subsequently conducted using the McNemar test of marginal homogeneity (FREQ procedure with AGREE option in SAS) to compare the endorsement of barriers for managed care patients versus FFS patients. Under the null hypothesis that the marginal probabilities are the same, the McNemar test statistic has an asymptotic χ^2 distribution with 1 degree of freedom.

The Generalized Linear Model (GENMOD procedure in SAS) was used to examine the relationship between physician, practice, and community characteristics and perceived barriers to mental health services. The numbers of reported barriers to mental health referrals were not normally distributed, but instead were distributed like many data on counts. Typically, count data are best modeled as Poisson distributions and are typically under- or overdispersed relative to the standard Poisson distributions determined solely by their degrees of freedom. Because the counts of reported barriers can be affected by clinician and practice characteristics, we sought to use an overdispersed Poisson regression to determine what factors might be correlated with referral barriers. We reported P values of the χ^2 tests for the individual coefficient estimates. A standard .05 significance level was used.

RESULTS

Sample demographics are reported in **Table 1.** Participating clinicians were 43 years old on average, 53% male, and primarily pediatricians (70%).

Barriers to Mental Health Services

Primary care providers were asked to identify factors that limited their initiation of referrals for mental health problems among their managed care and FFS pediatric patients (**Table 2**). The frequency of yes responses for managed care patients versus FFS patients was compared for each type of barrier using the McNemar test for marginal homogeneity. PCPs were more likely to report barriers to mental health services among managed care patients compared with their for FFS patients for 11 out of 12 barrier types. For instance, 47% of PCPs indicated that complex appeals process for out-of-plan providers limited their ability to refer managed care patients for mental health services, while only 9% of PCPs reported the same barrier for FFS patients ($P <$ .0001). Furthermore, 41% of clinicians stated that

Table 1. Description of Sample (n = 319)

Characteristic	n (%)
Average age	43 ± 8 years
Sex	
Male	169 (53%)
Female	150 (47%)
Discipline	
Pediatrics	225 (70%)
Family practice	79 (25%)
Other*	15 (5%)
Practice structure	
Single specialty	193 (61%)
Multispecialty	125 (39%)
Primary practice area	
Urban	79 (25%)
Suburban	153 (49%)
Rural	81 (26%)
Mental health training	
Residency rotation	172 (54%)
Fellowship	16 (5%)
Mental health professional is onsite at least 1 day a week	102 (32%)
Community child mental health resources accessible/available	132 (46%)

*Other includes nurse practitioner and physician assistant.

authorization procedures limited the number of referrals made for managed care patients, compared with 13% of clinicians endorsed the same barrier for FFS patient population ($P < .0001$). In contrast, reports of specialists limiting or not accepting Medicaid coverage were comparable between patients with managed care (49%) and FFS (47%) coverage. Among managed care patients, the most common restrictions included difficulty or delay in getting an appointment with a mental health specialist (n = 196, 62%), lack of availability of an appropriate specialist (n = 177, 56%), and physician panel restrictions (n = 167, 53%).

Predictors of Barriers for Patients With Managed Care Coverage

We used the GENMOD procedure to analyze the influence of practice structure, the interdisciplinary nature of office settings, and the availability of child mental health community resources on PCP perceptions of barriers to mental health referral for managed care patients. We controlled for clinician and practice factors in the regression model. These factors included demographics, training, beliefs,[21] and location.

Using the total number of barriers endorsed by PCPs as the criterion variable, 2 statistically significant predictive results emerged (**Table 3**). Consistent with our hypothesis, the total number of barriers endorsed by physicians was higher among patients with managed care versus with FFS coverage ($P < .00001$). In terms of factors predictive of mental health referral barriers, as hypothesized, the greater the availability of community mental health resources, the lower the number of barriers reported by PCPs ($P < .0001$). Contrary to our hypotheses, neither practice structure nor the interdisciplinary nature of the office setting was related to the level of mental health barriers reported by clinicians.

DISCUSSION

The present study described high rates of perceived barriers to mental health referrals among a national sample of PCPs. In addition, significantly higher rates of barriers to mental health referral were reported for managed care compared with FFS pediatric patients. While differences were found between managed care and FFS coverage, the overall frequency of perceived referral barriers suggests that similar challenges (eg, availability of pediatric mental health specialists) may extend across types of coverage.

In terms of the differences in perceptions found, the most common factors limiting referrals for children with managed care coverage included delays in access-

Table 2. Primary Care Physician-Reported Barriers to Mental Health Referrals (n = 319)

Barrier	Number (%) of Clinicians Responding Yes		McNemar Test Results	
	Managed care	Fee-for-service	S (df)	*P*
Lack availability of pediatric specialists	177 (56%)	133 (42%)	32.2667 (1)	<.0001
Lack of availability of pediatric inpatient care	107 (34%)	94 (29%)	8.0476 (1)	.0046
Pressure to refer to adult specialists	43 (13%)	12 (4%)	31.0000 (1)	<.0001
Pressure to refer to adult inpatient care	14 (4%)	6 (2%)	8.0000 (1)	.0047
Physician panel restrictions	167 (53%)	42 (13%)	121.1240 (1)	<.0001
Financial disincentives	90 (28%)	58 (18%)	16.0000 (1)	<.0001
Authorization procedures	131 (41%)	42 (13%)	83.3789 (1)	<.0001
Complex appeals process for out-of-plan	150 (47%)	28 (9%)	120.0323 (1)	<.0001
Burdensome authorization paperwork	93 (29%)	37 (12%)	47.5152 (1)	<.0001
Peer pressure to contain costs	50 (16%)	21 (7%)	27.1290 (1)	<.0001
Difficulty/delay getting appointment	196 (62%)	171 (54%)	15.2439 (1)	<.0001
Specialist limit/won't accept Medicaid	155 (49%)	147 (47%)	.9412 (1)	.3320

*Managed care includes health maintenance organization, preferred provider organization, or independent practice association coverage. S indicates statistic; df, degrees of freedom.

ing services, lack of availability of pediatric specialists, and physician panel restrictions. While practice structure and the interdisciplinary office staff were not found to be significantly associated with referral barrier perceptions for managed care, high availability of mental health services within the community was predictive of a lower prevalence of referral barriers.

The present findings are indicative of several prominent issues in child and adolescent mental health policy, with particular relevance to the effects of managed care on behavioral health.[22,23] With the emergence and predominance of managed care, increased emphasis has been placed on the generalist's role in caring for patients. The role of the primary care clinician has shifted to serve as a gatekeeper, determining when to initiate referrals for specialty services and facilitating the referral process between primary and specialty care for patients.[24] As a result, PCPs have greater responsibility for detecting psychosocial concerns and determining when it is necessary to link patients to more specialized mental health providers.

Based on the present findings, PCPs commonly perceive barriers to mental health services when determining whether to pursue a referral, and these obstacles may prevent them from successfully linking patients to mental health providers, particularly when treating patients with managed care coverage. The measurable influence of perceptions of referral barriers on actual clinician practice may be more limited than expected, as evidenced by other research that has not found a relationship between the intensity of managed care and access to mental health specialists.[25] Moreover, previous studies have not documented a direct relationship between clinician reports of referral barriers and clinical management decisions, questioning the influence of perceptions on actual behavior and generating consideration of other factors in future research that may more directly influence clinician behavior.[12,17]

Limitations

Several limitations of the present study were evident and warrant discussion. First, in order to increase the ease of completing the self-report survey, the instrument examined the frequency of preselected barriers, rather than allowing respondents to independently nominate barriers. In addition, the instrument employed a yes/no format, rather than a Likert-type scale to assess the level of impact of each barrier on referral practices. These characteristics of the survey, in addition to the lack of additional items to further assess the reasons behind the presence or absence of perceived referral barriers provided general and descriptive data, rather than more detailed or process-oriented information. Moreover, the findings reflect data from physicians, rather than incorporating patient/family perspectives concerning mental health referral, which is an important area for further study. In addition, the use of a self-report instrument provided subjective measurement, and this study did not objectively verify the presence or absence of obstacles to mental health services.

Clinical/Practice Implications

The findings emphasize the need to increase availability of community-based mental health resources for children and families, particularly for patients with managed care coverage. Increasing PCP awareness of mental health resources available to managed care recipients is another important priority in order to improve linkages between pediatric primary care and mental healthcare for children and families with psychosocial concerns. The importance of the accessibility of community-based mental health providers demonstrates the need for qualified mental health professionals to become eligible providers for a range of managed care plans.[26] Training PCPs to recognize psychosocial concerns, to make appropriate decisions regarding referrals, and to facilitate linking patients with treatment represent additional important implications of the study. The use of new coding systems, such as the Diagnostic and Statistical Manual for Primary Care

Table 3. Results of Overdispersed Poisson Regression of the Count of Barriers Endorsed by Clinicians (n = 281*)

Parameter	Estimate	*P*
Clinician gender	.0361	.5969
Clinician age	–.0031	.4668
Pediatrician	–.0125	.8604
Mental health training	.0606	.3732
Physician mental health beliefs	–.0045	.6820
Practice structure	–.0798	.2666
Rural practice area	–.1194	.1353
Practice managed care penetration	.0007	.6897
Availability of child mental health resources	–.3992	<.0001
Interdisciplinary practice setting	–.1266	.0929
Insurance type (fee-for-service vs managed care)	–.5783	<.0001

*n = 281 owing to missing values.

(DSM-PC), represent such training opportunities and applications for clinical practice.[27]

Policy Implications

The present findings concerning PCP-reported barriers to mental health referral underscore the relevance of the recent consensus statement on insurance coverage and mental health published by the American Academy of Pediatrics in 2000. The findings lend empirical support for the recommendations to reduce administrative burdens placed on PCPs, expand availability of child mental health providers, and improve coordination of service delivery.[28] In order to maximize the feasibility of initiating referrals for mental health services from primary care settings, healthcare policy changes are needed. Most notably, the prevalence of mental health concerns and the importance of early identification and intervention are key priorities.

Research Implications

The multiple layers of barriers impeding the ability of pediatric providers to readily refer patients to mental health services identified in the present study warrant further research. Most importantly, intervention-focused research that examines creative practice strategies for facilitating connections between pediatric and behavioral healthcare services and eliminating referral barriers is indicated.[29,30] Further research should examine treatment models and clinical training protocols that provide primary care patients with mental health services when indicated and monitor the outcomes of care to investigate differences between type of coverage and treatment access, as well as treatment outcomes. In addition, research that examines the impact of the relationship between primary care and mental health would be valuable and could inform the management of behavioral problems in primary care, guide training of pediatric practitioners, and suggest policies to limit the most salient obstacles to mental health services for patients.

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