

# MENTAL HEALTH AND MENTAL DISORDERS—A RURAL CHALLENGE

by Larry Gamm, Sarah Stone, and Stephanie Pittman

## SCOPE OF PROBLEM

- A survey of state and local rural health leaders finds mental health and mental disorders to be the fourth most often identified rural health priority.<sup>43</sup>
- Mental health is one of the 10 “leading health indicators” selected through a process led by an interagency workgroup within the U.S. Department of Health and Human Services.<sup>44</sup>
- Psychoses is virtually tied with cancer as the fourth most frequently first-listed diagnoses for hospital discharges nationally.<sup>45</sup>
- The suicide rate among rural males is higher than among their urban counterparts across all four regions of the nation.<sup>20</sup>
- Among 1,253 smaller rural counties with populations of 2,500 to 20,000, nearly three-fourths of these rural counties lack a psychiatrist, and 95 percent lack a child psychiatrist.<sup>16</sup>
- Access to mental health care and concerns for suicide, stress, depression, and anxiety disorders were identified as major rural health concerns among state offices of rural health.<sup>46</sup>

## GOALS AND OBJECTIVES

Mental disorders affect approximately one-half of the population over a lifetime.<sup>1</sup>

chronic diseases.<sup>2,3</sup> In a recent survey of state and local rural health leaders, mental health was the fourth most often selected topic as a high rural health priority. Mental health was rated a priority most frequently by rural health centers and clinics and by state organizations associated with rural health. It

Mental disorders affect approximately one-half of the population over a lifetime<sup>1</sup> and are among the most impairing of

was among the top five most frequently selected rural health priorities in all four regions of the country.<sup>4</sup>

This summary addresses the Healthy People 2010 mental health and mental illness goal—improve mental health and ensure access to appropriate, quality mental health services<sup>5</sup> emphasizing access to treatment by mental health providers in rural areas. This overall goal encompasses three of the 467 specific Healthy People 2010 objectives. These include:

- 18-6. Primary care screening and assessment.
- 18-7. Treatment for children with mental health problems.
- 18-9. Treatment for adults with mental disorders.

## PREVALENCE

Mental disorders are widespread in urban and rural areas alike and affect approximately 20 percent of the population in a given year.<sup>6,7</sup> Moreover, mental illness is distributed across all age groups. An estimated 20 percent of children and adolescents age 9 to 17,<sup>8</sup> and as many as 25 percent of those 65 years and older<sup>9</sup> suffer from mental illness each year. Of those who experience a mental disorder, only a minority report treatment in the preceding year.<sup>10</sup>

The prevalence of mental disorders appears to be similar in rural and urban areas;<sup>6,11,12</sup> however, there are some noteworthy exceptions. Poverty, age, being African American, and living in a rural area have been associated with a low, or a lower, likelihood of receiving mental health care.<sup>13</sup> African Americans and rural residents underutilize mental health services and seek help later in the course of the disease.<sup>14,15</sup> Rural areas are especially disadvantaged in meeting the needs of children with serious mental health problems because of the relative lack of

psychiatrists, and especially child psychiatrists, in rural areas.<sup>16</sup> The elderly are also at risk. While as many as a quarter of elderly people may suffer from mental disorders, less than 5 percent of mental health professional's practice time is spent with elderly.<sup>17</sup>

**Rural areas are especially disadvantaged in meeting the needs of children with serious mental health problems.**

## IMPACT

Among all illnesses and health behaviors, mental disorders have been identified as one of the leading contributors to disability and associated disease burden, defined as years of life lost to premature death and weakened by disability.<sup>3, 18</sup> Also, mental illness is often a contributor to and/or a consequence of disabilities or other serious health-related conditions among the nation's most vulnerable populations such as the homeless, alcohol or substance abusers, and abusing families.<sup>19</sup>

The impact of mental health and mental disorders on mortality in rural areas appears in several forms. Suicide rates, a standard indicator of mental illness, are higher in rural areas, particularly among adult males and children.<sup>12, 20</sup> More suicide attempts, too, occur among depressed adults in rural areas than in urban areas.<sup>21</sup>

Depression is an important cause of morbidity and a frequent co-morbidity for other illnesses. According to a report from the U.S. Surgeon General,<sup>18</sup> depression is the second leading cause of years lost because of premature death or disability among established market economies. More specifically, there is evidence that depression, anxiety, and other psychosocial factors contribute to progression and outcomes associated with chronic illnesses, such as heart disease.<sup>22</sup>

Morbidity differences associated with mental illness among rural versus urban residents are not

consistent. No differences in one-year symptom outcomes are observed in studies comparing rural and urban people with depression.<sup>23</sup> Worse symptom outcomes in rural areas, however, are observed among those with more serious mental illness, especially with co-occurring substance abuse.<sup>24</sup>

Although relatively little is known about the causes of mental illness, a number of factors have been identified that may contribute to mental disorders, to their consequences, or to failure to adequately treat the disorders. Stress is frequently associated with the appearance of mental disorders such as anxiety and depression. Stresses associated with economic hardship, e.g., the farm crisis of the 1980s or loss of a major employer, can affect the mental health of rural populations.<sup>25, 26</sup> Stressful life events along with mental disorders and substance abuse disorders are among the risk factors for suicide.<sup>27</sup>

## BARRIERS

Rural areas suffer shortages in mental health infrastructure and supply of mental health professionals.

**Use of outpatient mental health services is lower in rural areas than in urban areas.**

Twenty percent of non-metro counties lack mental health services; the same is true in only 5 percent of metro counties. Non-metro counties have on average less than two specialty mental health organizations, while metro counties report an average in excess of 13 mental health organizations.<sup>12, 28</sup> In 1999, 87 percent of the 1,669 Mental Health Professional Shortage Areas (MHPSAs) in the United States were in non-metropolitan counties.<sup>29</sup>

Greater travel distance to outpatient services is common in rural settings. It is associated with fewer mental health visits by patients and with a lesser likelihood of receiving care in accordance with treatment guidelines.<sup>30</sup> This and other barriers may account for findings that use of outpatient mental health services is lower in rural areas than in urban areas.<sup>13, 21, 31-34</sup> However, according to one recent national study, rural residents are less likely to report

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unmet treatment needs for serious mental illness than young adults and those residing in nonrural areas.<sup>35</sup> Primary care physicians who practice in rural and frontier areas play an even larger role in mental health care than their urban counterparts.<sup>36</sup> This may be attributed both to the scarcity of mental health professionals<sup>11</sup> and to the stigma-associated reluctance among rural residents to see a mental health professional.<sup>37, 38</sup>

Treatment of mental illness by primary care practitioners, however, faces a number of practice and professional constraints including insufficient training and skills, heavy patient case load,<sup>32, 36</sup> lack of time,<sup>36</sup> and lack of specialized backup.<sup>39</sup> Some researchers find that primary care physicians deliberately underdiagnose mental illness because of stigma, doubts about the patient's acceptance of a mental disorder diagnosis, or a concern for the patient's future insurability.<sup>40, 41</sup>

Finally, recognition and perception of mental illness may reduce utilization of mental health care in rural areas. Evidence indicates rural persons suffering from mental disorders may be less likely than their urban counterparts to perceive a need for mental health care.<sup>13</sup> A lack of anonymity in rural communities and the perceived social stigma associated with mental illness may also prevent treatment-seeking behavior.<sup>26, 42</sup> In one recent national study, however, rural residents with serious mental illness were less likely than nonrural residents to report stigma as a reason for not seeking treatment.<sup>35</sup>

## PROPOSED SOLUTIONS

A number of solutions to the rural undersupply of mental health professionals have been proposed and attempted. Among these are:

- identification of MHPSAs,
- improved training and recruitment of rural mental health professionals,
- greater reliance upon primary care practitioners for mental health care,

- improving linkages between primary care physicians and mental health specialists, and
- dependence on managed behavioral health care programs to attract mental health professionals.

## SUMMARY AND CONCLUSIONS

Mental health and mental disorders are serious problems in rural areas. These problems arise because of the frequent failure to identify such conditions early on, lack of access to mental health professionals to treat such conditions, and the tremendous consequences of mental illness for treatment of physical illnesses and for day-to-day life. Mental health needs occur among men, women, and children of all ages, ethnic groups, and social backgrounds. Some of these groups appear particularly disadvantaged in rural areas in gaining necessary treatment. Among these groups experiencing rural disparities are children, the poor, the elderly, and African Americans and other minority groups.

Concerns regarding anonymity in treatment and the associated stigma may be more pronounced among rural populations. These factors, combined with the existence of stressful occupations and the lack of knowledge of mental illness symptoms or treatments, may reduce utilization of mental health care. The continuing shortage of mental health professionals in rural areas creates serious access problems. It is all the more important, therefore, that rural primary care practitioners receive continuing training in mental health diagnosis and treatment. Similarly, ongoing attention to coordination between physicians, mental health specialists, and other formal and informal sources of mental health support is all the more critical to rural areas.

## MODELS FOR PRACTICE

The following models for practice are examples of programs utilized to address this rural health issue.

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## MODELS FOR PRACTICE

### FOCUS AREA: MENTAL HEALTH AND MENTAL DISORDERS

**Program Name:** Pro Bono Counseling Program, Mental Health Association of the New River Valley, Inc.

**Location:** Blacksburg, Virginia

**Problem Addressed:** Access to Mental Health Services for the Uninsured

**Healthy People 2010 Objective:** 18

**Web Address:** <http://www.mhanrv.org>

#### SNAPSHOT

The Pro Bono Counseling Program is designed to provide mental health services to those who are low to moderate income, uninsured, and ineligible for Medicaid. Through partnerships with local mental health providers, the program provides free mental health services to eligible adults, children, and families. The program also provides free prescription services. Currently, the program serves 280 persons per year and provides nearly \$45,000 in free psychiatric medications. Each patient receives an average of seven units of counseling or medication-related services.

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#### THE MODEL

**Blueprint:** The Pro Bono Counseling Program provides mental health counseling and psychiatric services to low to moderate-income individuals up to 200 percent of the federal poverty level (FPL). The program's clients are uninsured and/or ineligible for assistance programs such as Medicaid. It delivers free mental health services, short-term solution-focused counseling, and medication evaluations. The program currently partners with 35 mental health providers throughout the 1,400 square mile region, with nearly 40 percent of the mental health providers donating their time. To expand their pool of service providers, the program also partners with local universities. Unlicensed graduates of masters and Ph.D. programs in mental health related fields see four clients per week; the program pays a qualified supervisor to provide the required clinical supervision once a week. Services are delivered in the provider offices as well as during special clinic nights and at nonprofit locations such as libraries in the more rural areas.

Additionally, the program coordinates medication evaluations. While pharmaceutical companies provide free samples, the program also uses a voucher system to pay for medications when free samples are not available. The program also benefits from The Pharmacy Connection software, which expedites applications to pharmaceutical companies' indigent drug programs.

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**Making a Difference:** To measure the program's effectiveness, an outcome and satisfaction survey is annually administered to randomly selected clients. All responding clients report they would refer a friend to the program. On a scale of 1 to 10 (10 being the highest satisfaction rating), the program has received a rating of nine. Outcome measurement finds that nearly 60 percent of clients complete their treatment, and there is a no-show rate of only 10 percent. Severity of symptoms and difficulties in work life and personal life were cut in half.

**Beginnings:** The Pro Bono Counseling Program is a collaborative initiative of the New River Valley Partnership for Access to Healthcare (PATH). PATH is a community-focused alliance comprised of over 40 health and human services organizations, community organizations, and businesses. PATH was created to address the health concerns of the New River Health District, which consists of 1,400 square miles encompassing rural and suburban regions in southwest Virginia. A needs assessment conducted in 1996 revealed stress, anxiety, and depression occurred in 31 percent of the homes surveyed, prompting the need for increased access to mental health services.

The Mental Health Association of New River Valley serves as the coordinating agency for the Pro Bono Counseling Program. The program began with receipt of a four-year grant from a local hospital foundation. Using the grant money, the Pro Bono Counseling Program has grown and currently has three part-time paid staff who coordinate the clinical services provided by the volunteer and trainee providers.

**Challenges and Solutions:** One of the foremost challenges encountered by the Pro Bono Counseling Program is the pursuit of funding sources. While a local hospital foundation provided initial funding, the Pro Bono Counseling Program sought and received additional funding from a statewide health care foundation. In addition, the program faced challenges in recruiting mental health provider volunteers. By partnering with local universities, post-graduate, license-eligible trainees are utilized to provide direct services to clients and also gain valuable experience. Medicaid requirements in the state of Virginia require that state mental health agencies see only the priority population (defined as severe and emergency). Therefore, as fewer patients are seen by state agencies, more patients seek the services of the Pro Bono Counseling Program.

The majority of the program's clients are referred by word of mouth; however, the program does utilize a variety of other marketing tools to publicize their program. The program advertises through program brochures and ads in the newspaper. It recently initiated an anti-stigma campaign to address societal barriers to seeking mental health care.

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The program has received a number of awards. It won the 2000 Innovation in Programming Award by the National Mental Health Association. It was also a semifinalist for the American Psychiatric Association's Golden Community Award and the Premier Cares Award.

Finally, to offer the opportunity for other areas of the country to replicate the program, the program offers a Program Development Guide, which includes a program handbook and all the forms and documents (including the original grant) needed for other sites to create their own Pro Bono Counseling Program. The guide may be purchased from the program.

### **PROGRAM CONTACT INFORMATION**

Amy Forsyth-Stephens, Executive Director  
Mental Health Association of the New River Valley, Inc.  
Pro Bono Counseling Program  
303 Church St.  
Blacksburg, VA 24060  
Phone: (540) 951-4990  
Fax: (540) 951-5015  
E-mail: [mhainfo@mhanrv.org](mailto:mhainfo@mhanrv.org)



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## MODELS FOR PRACTICE

### FOCUS AREA: MENTAL HEALTH AND MENTAL DISORDERS

**Program Name:** Sowing the Seeds of Hope

**Location:** Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin

**Problem Addressed:** Mental Health Access for Rural Farm Families

**Healthy People 2010 Objective:** 18-7, 18-9

**Web Address:** <http://www.agriwellness.org>

#### SNAPSHOT

Sowing the Seeds of Hope: Responding to the Mental Health Needs of Farm Families is a collaborative effort of project leaders in seven predominantly rural states: Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin. The program is establishing an integrated regional network of behavioral health care supports for the rural agricultural population.

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The project in the seven states addresses the underserved rural agricultural population without regard to age, income, availability of insurance, racial/ethnic group, or location.

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#### THE MODEL

**Blueprint:** Sowing the Seeds of Hope provides behavioral health assistance in participating states to those involved in the agricultural business and their families. The project in the seven states addresses the underserved rural agricultural population without regard to age, income, availability of insurance, racial/ethnic group, or location.

The program provides services to individuals and families who do not have health insurance or adequate behavioral health coverage, and others who are unable to pay for necessary care. Often, these individuals and families experience an accumulation of stresses that result in the breakdown of coping mechanisms. Common associated behavioral health problems include interpersonal distress, depression, anxiety, substance misuse, and loss of hope. Negative stigma about mental health services, geographic barriers, and a perception that providers do not understand their agricultural issues often deters some families from seeking necessary assistance. Additionally, there is a scarcity of qualified professional service providers in rural areas, necessitating the training and utilization of informal networks of support, such as clergy, Extension staff, trained natural helpers who reside in the farm community, and primary care providers (e.g., physicians, nurse practitioners, and physician assistants).

Sowing the Seeds of Hope was designed and initiated in 1999 by the Wisconsin Office of Rural Health and Wisconsin Primary Health Care

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Association. It was supported by grants from the U.S. Department of Health and Human Services Office of Rural Health Policy and Bureau of Primary Health Care. Administrative support for Sowing the Seeds of Hope is now coordinated by AgriWellness, Inc., a 501(c)(3) nonprofit corporation that assists project leaders in the seven states, provides proposal and grant writing, and explores funding opportunities.

Many individuals and organizations serve voluntarily in their specific states to carry out portions of the work. A central aim of each state project is the formation of a coalition of individuals (both paid staff members and volunteers), agencies, and organizations to maximize information about access and cost of services, options for additional funding, and continuation of the state projects.

Project leaders identified 11 core services for the underserved rural agricultural community:

- outreach;
- training and education of traditional and non-traditional behavioral health care providers;
- education of the community on agricultural behavioral health issues;
- information clearinghouses;
- crisis hotlines;
- direct services through vouchers, contracts with approved providers, and other means to ensure access to necessary services;
- prevention of more serious difficulties through early intervention;
- coalition building with organizations, agencies, and communities;
- advocacy for behavioral health of the underserved;
- social marketing through publications, press releases, and other media activities; and
- retreats and support group activities for farm couples and families.

**Making a Difference:** To evaluate the core activities of the program, the following evaluation measures are used:

- outreach: documentation of the type of outreach and purpose;
- training and education: community education—documentation of the type of participants and training, numbers of people and sessions, and duration of sessions;
- clearinghouse: number of requests, referrals, and types of information;
- crisis hotline: number of people calling, referrals, and outcomes;

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- direct services: numbers of vouchers, types of services, demographic information, and dollars allocated;
  - prevention/early intervention: numbers of people served, type of activity, and demographic information;
  - coalition building: type and number of meetings; direct/indirect;
  - advocacy: number of contacts, amounts of finances received/leveraged; and
  - retreats/support activities: type of activity, numbers of participants, and duration of sessions.

Since the outcome criteria were not established until December 10, 2001, not all the reported data are usable. Thus, the outcomes/results reported here for 2001 are probably underestimates.

More than 14,000 farm residents were reached in 420+ outreach events. More than 400 providers were documented as having received professional training in 40+ documented training programs. At least 5,850 farm residents received community education. The crisis hotlines in the seven states reported more than 20,000 callers during the first two years of the project. At least 3,811 farm residents received direct services, which were partially or completely funded by Sowing the Seeds of Hope. Project personnel were successful in generating an additional \$3,150,000 of federal, state, and private funds to augment \$1,035,000 received from the Federal Office of Rural Health Policy, \$90,000 from the Federal Bureau of Primary Health Care, and \$28,000 from the Land O' Lakes Foundation. At least 556 persons participated in 95 support group meetings or farm couple/farm family retreats.

**Beginnings:** The Sowing the Seeds of Hope project was developed to respond to the mental health needs of farm families in the seven-state region. Behavioral health threats increase among the rural agricultural population during eras of economic stress. The suicide rate among farmers rose three to four times the national average during episodes of financial distress in several of the states in the Sowing the Seeds of Hope region.

The program began in May 1999 and was fully implemented in September 2000. The first three years of funding were considered the pilot phase. The Sowing the Seeds of Hope project leaders are now ready at the next level—implementing the basic services on an ongoing basis.

**Challenges and Solutions:** Insufficient funding is the greatest challenge to the projects in each state. Although project leaders in each state have been very successful leveraging additional state, private, and federal resources to augment their projects, the needs of the population surpass available resources. The program is working very actively with federal, state, and

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private organizations to both secure additional funds and to maximize pursuit of the program's objectives.

**PROGRAM CONTACT INFORMATION**

Michael R. Rosmann, Ph.D., Executive Director, AgriWellness, Inc.  
1210 7<sup>th</sup> Street, Suite C  
Harlan, IA 51537  
Phone: (712) 235-6100  
Fax: (712) 235-6105  
E-mail: [info@agriwellness.org](mailto:info@agriwellness.org)

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## MODELS FOR PRACTICE

### FOCUS AREA: MENTAL HEALTH AND MENTAL DISORDERS

**Program Name:** Thomas E. Langley Medical Center—Behavioral Health Department

**Location:** Sumterville, Florida

**Problem Addressed:** Mental Health and Mental Disorders

**Healthy People 2010 Objective:** 18

**Web Address:** [thomaselangleymedical.com](http://thomaselangleymedical.com)

#### SNAPSHOT

The Behavioral Health Department at the Thomas E. Langley Medical Center (TELMC) is a recently created department within this Federally Qualified Health Center that focuses on the mental health needs of the people of rural Sumter County. The program's mission is to serve all residents regardless of their ability to pay. This is accomplished through grant funding and some billing through Medicare, Medicaid, and private insurance.

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The department addresses all mental/behavioral health issues of people in all age groups within the catchment area, including a large Hispanic population.

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#### THE MODEL

**Blueprint:** The Behavioral Health Department serves all residents of Sumter County, Florida, regardless of ability to pay. The staff for this department consists of a full-time psychologist, two full-time licensed clinical social workers, a part-time psychologist, a case manager, and an office manager. Behavioral Health receives referrals from many specialists ranging from pediatricians to gerontologists. The department addresses all mental/behavioral health issues of people in all age groups within the catchment area, including a large Hispanic population.

The services are delivered on-site at TELMC, in a building designated for Behavioral Health Services. The department provides psychological evaluation services, traditional therapeutic services, specialized programs, and services for attorneys and courts. The psychological evaluation services include psychological testing, intellectual testing, psycho-educational testing, and alcohol and drug addiction evaluations. The traditional therapeutic services include child, adolescent, and geriatric therapy; employee assistance programs; and coping/life management skill development. Specialized programs address attention deficit hyperactivity disorder (ADHD), pain management, loss and grief issues, stress management, domestic violence, and sexual abuse. It also provides social skills training, addictions education and counseling, cognitive assistance programs, random drug screening, and rapid saliva alcohol testing.

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Additionally, the program provides services for attorneys and courts, including competency determinations, diversion programs, custody evaluations, identifying substance abuse, and making treatment recommendations. Group therapy, marital counseling, family therapy, conjoint therapy, pain management group, parenting and educational seminars, couples counseling, teen group, and children's group round out the complement of behavioral health services offered by TELMC.

The department coordinates the center's participation in the National Health Disparities Depression Collaborative. The Collaborative allows the center to share data and exchange best practices with other centers throughout the country. The Collaborative is an ongoing endeavor to ensure the highest quality of patient care.

Also, there are many outreach endeavors that are ongoing to serve the entire Sumter County population. Sumter County is approximately 546 square miles with a total population of just over 50,000. Many of the residents are seasonal—from retired persons who live in the area from October to April to migrant workers who stay through the citrus harvest season. The median income falls within the lower middle class range.

**Making a Difference:** To measure the success of the program, the following indicators are monitored: psychologists' productivity, decrease in the number of "no-shows" from baseline data, number of network panels in which staff are accepted for third-party payment, and patient satisfaction. Other quality-related indicators include quality assurance chart reviews, physician review for medical necessity as appropriate, and annual internal quality council review accessing progress on the above measures and developing new goals.

**Beginnings:** Behavioral Health began in August 2000 and was fully implemented in February 2001. It started in response to several primary care physicians' recognition of mental health problems in many of their established patients. Before it was established, these mental health needs had to be addressed by outside referrals, which limited access to care and follow-up and resulted in inadequate treatment of behavioral health problems.

**Challenges and Solutions:** Behavioral Health has been successful in its endeavors to integrate primary health care and mental health, and to sustain itself financially. Lack of funds, however, has prevented expansion of the program to meet all of the needs of the community. Behavioral Health's pursuit of increased access is complicated in part by the fact that Florida does not require insurance companies to include mental health coverage as part of their plans. Also, of the companies that do provide coverage, it is often difficult for new professionals and organizations to become a part of the panel of licensed professionals permitted to be reimbursed for services

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provided. During the initial year, TELMC made a commitment to absorb any losses. Behavioral Health is applying for a grant to provide services to children and families who are affected by domestic abuse. In addition, Behavioral Health is seeking funding through a hospital-based foundation for equipment and direct services for patients and their families who cannot afford care. Behavioral Health is marketed to new clients through newspapers, its web page, and community involvement.

### **PROGRAM CONTACT INFORMATION**

William J. Kuzbyt, Psy.D.  
Behavioral Health  
1489 W. Hwy 301  
Sumterville, FL 33585  
Phone: (352) 793-5900 ext. 3046  
Fax: (352) 793-3959  
E-mail: bkuzbyt@hotmail.com



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## MODELS FOR PRACTICE

### FOCUS AREA: MENTAL HEALTH AND MENTAL DISORDERS

**Program Name:** Turning Point Counseling Services, Inc.

**Location:** Corpus Christi, Texas

**Problem Addressed:** Mental Health and Mental Disorders

**Healthy People 2010 Objective:** 18

**Web Address:** None

#### SNAPSHOT

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TPCS addresses the problem of limited access to mental health services in the community.

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Turning Point Counseling Services, Inc. (TPCS) is an independent agency that collaborates with other agencies to build a network of support and services for the Texas counties of Nueces, San Patricio, and non-metropolitan Aransas. TPCS addresses the problem of limited access to mental health services in the community. Other problems addressed are the high incidence of abuse, neglect, and exposure to violence and trauma in children, adults, and families in the area. TPCS also addresses the lack of access by families of “at risk” youth to community-based prevention and intervention services in San Patricio County. The populations served are low-income individuals and families who would generally not seek help because of the cost. TPCS provides free counseling services without limitations to the number of sessions.

#### THE MODEL

**Blueprint:** TPCS is organized as a 501(c)(3) not-for-profit agency. It utilizes volunteer services provided by Texas A&M University – Corpus Christi’s Master’s level counseling students to provide the majority of the free services. The number of volunteer students varies with each school semester. Additionally, TPCS has five paid staff members: an executive director, administrative assistant, victim’s services case management coordinator, and family intervention specialists. TPCS also has licensed counselors to see clients who have insurance. Beginning May 2002, a part-time clinical director was added to the team.

TPCS has three main programs: Victims of Crime, Outreach Services, and Familias Unidas. Victims of Crime serves individuals, children, and families from Aransas, Nueces, and San Patricio Counties who are child victims of physical and sexual abuse, domestic violence victims, adult survivors of abuse, and victims of sexual and physical assault. The majority of this group is uninsured, and the services to them are free. The Outreach Services Program serves children 5-17 and their families from Nueces and Aransas Counties who have been identified in some manner (self-report, referral

from a collaborating agency) as at risk. This group also has limited access to mental health care due to the lack of adequate insurance. The Familias Unidas Program targets families and children in San Patricio County and focuses on prevention and intervention for “at risk” youth.

TPCS provides individual, couple, family, and group counseling. TPCS also uses play therapy with children and goes to the schools to provide counseling as needed. If transportation is a problem, home visits for counseling are available. TPCS provides referral services, follow-up services, and collaborations with other area agencies. TPCS also provides educational/informational group presentations to agencies and groups who request this service.

The main office for TPCS is located in downtown Corpus Christi. On-site are two therapy rooms and a play therapy room, both with video capabilities. TPCS relies on donated space from several agencies such as churches, schools, and other buildings with office space to provide off-site services.

**Making a Difference:** TPCS utilizes a variety of measures to determine the elements of each program. The Victims of Crime Program uses a client case tracking system. Each client is placed in this system and tracked according to seven important categories: number of sessions utilized, type of victimization, age, ethnicity, county served, referral source, and disability.

To measure the level of activity, TPCS looks at the number of new victims as well as the number of sessions provided. Current data for the Victims of Crime Program are shown in the following table.

Tracking Categories	Reporting Year	Reporting Year
	1999–2000	2000–2001
Number of Sessions*	1,128	1,868
Number of New Victims	379	646
Average Number of Sessions per Victim	2.97	2.89

\*“Session” refers to direct service and group presentation.

Through the use of these outcome measures, TPCS is better able to determine the approximate length of treatment needed for each specific referral, the services most utilized by clients, the category of victimization group that needs services in the Tri-County area, and the referral sources that most utilize the agency for referrals/services to their clients. TPCS uses a mental health outcomes questionnaire and discharge follow-up as two measurement devices to ensure that clients are receiving therapeutic services. The same methods and categories for tracking clients used in the Victims of Crime Program are used in the Outreach Services Program.

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For the “Familias Unidas” Program, TPCS developed a tracking system for all clients that identifies six important categories: referral source, county/city served, number of sessions/groups attended, age group, ethnicity, and disability.

Historically, although parents of youth involved in Familias Unidas participate in initial sessions, they frequently drop out and do not actively participate in ongoing services. The percentage of parents who stay in treatment after the initial session will be monitored as an indicator of effectiveness.

**Beginnings:** TPCS was started in 1997 by a group of licensed professionals as a clinical internship and was fully implemented in 1999. The program began in response to increasing violence and neglect identified in the community. These problems were identified in the Nueces County Community Plan as well as in the Community Plan for Aransas, Bee, Live Oak, McMullen, and San Patricio Counties. Of these counties, Aransas, Bee, Live Oak, and McMullen are non-metropolitan. The statistics for this area support that these problems are on the rise.

**Challenges and Solutions:** The program has been awarded several grants that will fund positions and programs for a minimum of one year and up to three years. The first funding source came from the Criminal Justice Division/421 fund in 1999. A Victims of Crime Act (VOCA) grant was received that same year. These two grants funded the executive director position, administrative assistant position, and one counselor position. A series of grants since January 2001 have enabled the organization to launch the Familias Unidas Program and to hire staff members to support the program efforts.

TPCS expanded at a rapid rate. While this expansion was beneficial, adequate time is needed to implement effective tracking systems to keep up with the expansion.

## **PROGRAM CONTACT INFORMATION**

Christine Gullett  
Turning Point Counseling Services, Inc.  
520 Lawrence Street  
Corpus Christi, TX 78401  
Phone: (361) 888-5924  
Fax: (361) 882-4347  
E-mail: tpoint@birch.net

