White Paper: Meeting the Mental Health Needs of People Living in Rural Areas

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Preface

The study was conducted under a contract with the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration. The project and report focus on the nature of rural mental health service problems, promising practices and models for addressing these problems and related policy recommendations in three principal areas—mental health professional shortages, access to mental health services, and behavioral health systems in rural settings. Subsequent requests from the sponsor moved the project and the final product in the direction of covering a wider-range of topics in rural mental health.

The project reviewed over 200 articles, books, reports, and dozens of websites. Many of these are reflected in the references. In addition, interviews were conducted with researchers and other professionals in the field with expertise in rural mental health services to gain additional insights into current models and policy options.

Dr. Larry Gamm and Dr. Ming Tai-Seale conducted the major portion of the research and writing of the white paper. Ms Sarah Stone provided valuable research assistance throughout the project. The authors wish to acknowledge with gratitude the work of Dr. Craig Blakely and Dr. Catherine Hawes who offered valuable advice at different points in the project and reviewed and commented on the final product. The two lead authors, alone, are responsible for any error of omission or commission in the paper.

Finally, we thank Michele Edwards, MA, ACSW, Project Officer, Center for Mental Health Services, for her guidance and encouragement throughout the execution of the project, including her very informative comments on the initial draft of the report.

Executive Summary[*]

Nearly 60 million Americans living in rural and frontier America tend to have the same types of mental health problems and need for services as individuals who live in urban and suburban areas. However, comparable mental health care services are unavailable in many rural areas. The provision of mental health services in rural areas can be characterized as a small number of providers -- possibly one or two specialty mental health providers, primary care physicians, staff in rural hospitals and nursing homes, school counselors, social workers, ministers, law enforcement personnel, and self-help groups -- serving a large but sparsely populated geographical area.

Supply of Mental Health Providers

In 1999, 87 percent of the 1,669 designated Mental Health Professional Shortage Areas in the United States were located in non-metropolitan counties that were home to over 30 million people. Probably the greatest difference in mental health services in rural and urban areas is the availability of and accessibility to specialty mental health services. Among 1,253 rural counties with 2,500 to 20,000 people, nearly three-fourths lack a psychiatrist, and 95 percent lack a child psychiatrist. Only about 50 percent and 42 percent of these counties, respectively, have a psychologist or social worker, trained at the master's level or above, residing in the county, and working in the health care field. The supply of all of these types of mental health professionals is far lower in the 769 counties with fewer than 2,500 people.

Securing designation as a Mental Health Professional Shortage Area (MHPSA) can trigger national and state loan repayment programs. The goal of such programs is to attract mental health professionals to rural areas. Moreover, states are allowed to include clinical psychologists, clinical social workers, psychiatric nurse specialists, and licensed marriage and family counselors, along with psychiatrists, in designating mental health professional shortage that qualify for the recruitment incentive programs. Seeking designation as a MHPSA in order to attract mental health professionals to rural areas requires the availability of accurate information on current supplies and locations of mental health professionals.

> **<u>Recommendation 1.</u> National and state governments should join forces to make information on the current supply and location of mental health professionals more complete, accurate, and accessible to support recruitment efforts in rural areas.**

[*] In the interest of brevity, citations have been eliminated from the executive summary; the relevant references are included, however, in the more detailed discussion in the body of the report.

Training and Recruitment of Mental Health Professionals

Despite financial incentives such as loan repayment, potential providers may find rural areas unfamiliar or undesirable. They may be uninformed about rural mental health needs and/or practice conditions. Concerns over professional, cultural and social isolation may further prevent providers from committing themselves and their families to live in rural areas. Several educational programs for psychiatrists and/or psychologists employ multiple methods in professional education to increase the likelihood that mental health providers will seek practice opportunities in rural areas.

> **Recommendation 2.** **The number and training of rural mental health providers should be increased through multiple methods: a) rural-focused training for mental health graduate students, b) recruitment of rural-connected individuals into graduate training programs, c) training-related placement of mental health students in rural areas, d) provision of continuing professional education in area health education centers, e) innovation in reducing professional and social isolation in rural practice, and f) provision of additional governmental funding for training of rural mental health professionals.**

The Role of Primary Care Physicians in Mental Health

In many rural counties, primary care physicians are the only health professionals providing mental health services. From 10 to 20 percent of rural patients rely on primary care physicians annually for mental health services, and primary care physicians see the majority of patients who seek such services. A variety of conditions associated either with the training of primary care physicians or the ongoing demands of their practice may limit their ability of some to provide quality mental health services.

> **Recommendation 3:** **Medical school training, residency training, and continuing medical education, including major efforts within Area Health Education Centers (AHECs), must be directed at strengthening the ability of rural primary care providers to treat basic mental health needs.**

Linkages between Primary Care and Mental Health Professionals

Practices linking primary care providers and mental health professionals continue to be promoted to improve rural mental health services. A 1998 study identifies four models linking primary care and mental health: (1) diversification (mental health specialist hired by primary care physician to deliver services on-site at a primary care clinic); (2) linkage (primary care organization allows independent mental health specialist to deliver services on-site); (3) referral (patients of primary care providers use off-site mental health providers); and (4) enhancement (training primary care providers in mental health diagnoses). Some Federally Qualified Health Centers (FQHCs) in rural areas are moving forward on several of these models.

Recommendation 4. Federally Qualified Health Center (FQHC) program initiatives, Medicaid, and other federal and state programs, such as interdisciplinary training, should support linkages between primary care and mental health professionals.

Alternative Mental Health Providers

There is evidence of a rapid increase nationally in the supply of several types of clinically trained mental health professionals other than psychiatrists and clinical psychologists. These include counselors, marriage and family therapists, and school psychologists. No systematic studies were identified that examine the urban/rural distribution of these professionals or their roles in meeting rural mental health needs. In several areas experiencing severe under-service, the scope of practice rules for licensed professionals in meeting mental health needs is being reconsidered. For example, in New Mexico, the state licensing rules now authorize psychologists to prescribe psychotropic medications to their patients, a practice change that has also been studied in the military. These psychologists must be licensed, doctoral-level psychologists who have completed an additional training and certification program.

Recommendation 5. States should consider well-designed and carefully evaluated modifications to their scope of practice limitations, in combination with requiring additional advanced training relevant to any newly authorized practices, to enable additional health professionals to provide quality mental health services in areas in which psychiatrists are in scarce supply.

Telemental Health

Telemental health is another means of bringing mental health services to remote or otherwise underserved rural populations. Positive results are being reported from recent experiences with telepsychiatry that involved direct encounters between psychiatrists in an urban setting and patients in remote areas. Despite the high costs in rural areas, different types of telemental health may produce greater continuity of care and greater cost-effectiveness than the more intermittent care and more costly travel by mental health specialists to remote areas. Pursuit of telemental health options is likely to continue as a response to the severe rural shortages of specialty mental health providers.

Recommendation 6. Support for telemental health in rural areas should be sustained and evaluated as federal and state governments and private payers address reimbursement, cross-state licensure, telecommunications technology, and other issues.

Access to Mental Health Services

Disparities in access to mental health professionals in rural areas may be reflected in the prevalence of particular mental health conditions relative to availability of

treatment options or in differences in treatment received by particular rural populations. For example, the rate of depression among women in a rural underserved population is twice that found for the rural male population. Similarly, the elderly appear to be under-treated. Although an estimated 15 to 25 percent of elderly suffer from mental disorders, only two to four percent of mental health professionals' practice time is spent with elderly clients. In rural areas, evidence suggests that children with serious mental health problems are particularly disadvantaged in terms of having their care needs met. Children with mental illness receive mental health care from a variety of sources with their schools being the default care provider. Rural children are less likely to use these services. Thus, there are a number of disparities in access to mental health services that appear to affect persons living in rural areas.

Recommendation 7. Within rural areas, women, the elderly, and children or other groups who may be particularly vulnerable to untreated or under-treated mental illness should be considered as target groups for whom special programs may be appropriate.

Special Populations

African American and Native Americans are two minority populations with significant presence in rural America. Over half of the Latino population in the country resides in California and Texas with areas bordering Mexico which are mostly rural with primitive or no pubic health infrastructure. Little is known about the mental health status of these and other rural minority populations or their access to care. However, minority groups frequently report experiences with racism and discrimination in other areas of their lives that cause them ongoing distress. Under-use of formal mental health services may be a reflection of ethnic minorities' preference for more culturally sensitive care. In addition, minority members in rural American often rely on informal caregivers and may contact formal providers only during later stages of illnesses, when informal alternatives have been exhausted. Further, mistrust and discrimination further distance minorities from seeking care from providers and settings that are part of the dominant culture. When minority members who are poor seek formal care, they face an increasingly stressed safety net of community health centers, migrant health centers, and community mental health agencies that are frequently their primary source of care.

At the same time, closer attention to strengths associated with the cultures of special populations may benefit these populations and the larger society. The focus of Native Americans, for example, on harmony of the mind, body, and spirit, and their consideration of individual as well as collective strengths and means to promote mental health may very well teach all people – lay or professionals – of the fundamental aspects of health and well-being and prove valuable in promoting mental health.

Recommendation 8. Public and private mental health programs should promote cultural competency among mental health provider organizations and staff through recruitment, training, performance evaluation, incentives,

rewards, and sanctions and, at the same time, identify unique strengths that might reside within special populations.

Indigenous Social Support and Coordination

Some evidence suggests that rural residents tend to be less likely than urban residents to seek and use mental health services, despite experiencing as many or more symptoms of mental illness than persons in urban areas. The informal social network, smaller and tighter in many rural areas, may reduce anonymity for the person who needs mental health services. Evidence is emerging on the effectiveness of activating such informal networks, including family members, to identify mental health needs and to help the mentally ill recognize their illness and seek help.

Recommendation 9. Programs should target community opinion leaders, natural helpers, paraprofessionals, and family members to educate rural people to recognize mental health needs and the efficacy and value of treatment.

Stigma

A lack of anonymity in rural communities and the perceived social stigma associated with mental illness may prevent persons in need from seeking treatment. Both linkage strategies between mental health specialists and primary care providers, as discussed above, and other strategies may be helpful. For example, co-location of mental health services and primary care may improve stigma-free access to and use of mental health services (e.g., in FQHCs). Similarly, faith-based counseling services by certified or licensed professionals have attracted patients who are unwilling to seek out other mental health specialists. In addition, the design of mental health facilities and their environs, such as providing parking in the rear of the facility, might also provide greater anonymity to those for whom stigma is a barrier to seeking mental health care.

Recommendation 10. State mental health systems, managed behavioral healthcare organizations (MBHOs), and other provider organizations should continually explore opportunities to contract with certain types of patient-preferred providers and use other mechanisms that can help reduce the impact of stigma associated with seeking and receiving treatment for mental illness.

Insurance Barriers

Inequities in access to mental health services in rural and frontier populations may be attributable, in part, to an absence of parity in insurance coverage for physical and mental illness. Parity may help reduce mental health supply shortages in rural areas. Parity in mental health benefits in terms of consumer cost-sharing will also reduce financial burdens on those who do seek mental health services. Over thirty states have

taken some steps toward parity. Interest in the issue is beginning to reemerge in both the Congress and the Administration at the Federal level.

> **<u>Recommendation 11.</u> Parity in coverage between mental health services and physical health services should be pursued in federal and state law and regulation.**

Fragmented Public Funding

While more than 800 rural counties have high poverty rates, only 25 percent of people living in rural areas qualify for Medicaid, compared to 43 percent in urban areas. Medicaid payments, however, are often too low to attract a broad array of providers who are capable of providing optimal psychiatric care and treatment. Although Medicare pays for outpatient, inpatient and partial hospitalizations for treatment of mental illnesses, patient cost-sharing is higher for mental health services than for physical health services. State and local governments are the major payers for public mental health services. Funding is very important to the well-being of rural individuals with mental illnesses, though the funding mechanisms currently in place fail to meet their needs. In some sense, a variety of innovative mental health services integration efforts in place for children and, in a few instances, for the elderly can help to reduce impact of the funding patchwork. Medicaid expansion and the State Children's Health Insurance Program (SCHIP) have allowed some states flexibility in pooling funds from diverse funding streams to promote coordinated care.

> **<u>Recommendation 12.</u> Support is needed for service integration efforts for both children and adults that can identify sources of program support and eligibility for the range of necessary services for mentally ill persons.**

Managed Behavioral Health and Medicaid Managed Care

While most rural areas have low HMO penetration rates, the dominant form of managed behavioral health plans in rural areas is the Medicaid managed care plan. Though managed behavioral health organizations have been expected to improve access and quality of mental health care in rural areas, evidence suggests that they have fallen short of the mark in a number of states.

> **<u>Recommendation 13.</u> Managed behavioral healthcare organizations wishing to contract for providing services to rural residents should show actual capacity for providing care to rural areas and should be held accountable through rigorous accountability assessments.**

Disease Management

The timely treatment of mental illness has frequently been found to contribute to reductions in health care costs. Depression screening and depression management are areas currently receiving significant attention in this regard.

A health plan associated with a large, rural, multi-specialty group practice-based health system employs depression screening across all of its health plan patients who are participants in any of seven disease management programs. A two-question protocol is followed by a mood survey to determine if the patient should be referred to the primary care physician for further diagnosis and treatment.

An academic medical center and pediatric group practice partnership in Pittsburgh established a waiting room, touch-screen-based depression and substance abuse screening program for postpartum mothers. This serves as the basis for a referral to further care in a mental health specialty unit in an academic medical center.

> **Recommendation 14.** **Depression screening, depression management, and possibly other mental illness management approaches should be considered as part of a normal course of care for those receiving care funded by the federal government and state governments.**

Promoting Sustainable Development of Evidence-Based Practices

Assertive Community Treatment programs have become recognized as the most effective service delivery model for community treatment of severe mental illness by the National Alliance for the Mentally Ill. In assertive community treatment programs, clinicians provide continuous care in non-institutional settings and have been found to not only reduce inpatient psychiatric service use, but also improve clients' ability to live a meaningful community life outside of mental health institutions.

A pilot study developed an assertive community treatment program for patients in rural South Carolina and evaluated the effect of the program on rates of hospital utilization and cost of care. Although the methods of assertive community treatment may need to be modified to suit the travel requirements and other characteristics of rural settings, the study results suggest that the model can be successfully used in rural areas in reducing inpatient service use and costs.

A model of family preservation practices, home-based multisystemic therapy has been implemented successfully in a number of states and is undergoing rigorous evaluation for its applicability for rural and urban areas. The emphasis of multisystemic treatment is on providing a family- and community-based alternative to hospitalization for high-risk youths in psychiatric crisis. The focus of support is on building the strengths of the families, friends, schools and communities surrounding these youths.

> **Recommendation 15.** **Care coordination for mental health conditions (e.g., disease management, case management, assertive community treatment programs, multisystemic treatment, and numerous community initiatives in mental health treatment) should become integral parts of Medicaid, Medicare, and other government administered and privately insured, fee-for service, and MBHO delivered mental health services, especially in rural**

areas where there are not near enough mental health professionals to meet local needs.

Support for other promising practices.

Community-based health organizations or providers might take on responsibility for coordinating a range of services in support of the mental health needs of particular rural population groups, e.g., the elderly (like the Program for All inclusive Care for the Elderly-PACE) or youth (like county or regional youth service systems). Similarly, rural health organizations, e.g., rural FQHCs and critical access hospitals (CAHs), in some underserved rural areas are taking on greater roles in mental health services. The CAHs, too, are encouraged to develop rural health networks supporting coordination among local organizations and linkages to those in more populous areas. The cost-based reimbursement standards under which these two types of organizations function may provide greater stability for mental health services in the rural areas they serve.

Recommendation 16. Critical Access Hospitals (CAHs), FQHCs, and other primary care clinics should receive attention as possible coordination hubs for rural mental health services, especially in light of shortages of specialized mental health professionals and reliance on primary care physicians.

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Nearly 60 million Americans living in rural and frontier America tend to have the same types of mental health problems and need for services as individuals who live in urban and suburban areas. However, comparable mental health care services are unavailable in many rural areas. The provision of mental health services in rural areas is often dependent upon a handful of providers including possibly one or two specialty mental health providers, primary care physicians, staff in rural hospitals and nursing homes, school counselors, social workers, ministers, law enforcement personnel, and self-help groups (National Institute of Mental Health [NIMH], 2002).

Rural areas have many unique characteristics, many of which affect access and utilization of mental health services. For example, women head 46 percent of rural households, and, of these families, 27 percent are below the poverty level, compared to 9% of male-headed rural families. The elderly are represented disproportionately in rural areas. African Americans are over-represented in the rural South whereas a significant number of Native Americans and Alaska Natives live in rural and frontier areas in the West (U.S. Department of Health and Human Services [DHHS], 2001). Most rural counties have no practicing psychiatrists, psychologists or social workers. Providers with formal mental health training prescribe only 20 percent of psychotrophic medications. The relative absence of pediatric psychiatrists and undersupply of pediatricians in rural areas present a disadvantage to rural children with mental illness, especially severely mentally ill children. In sum, availability of, and access to, mental health specialists (and often any kind of provider) remain serious problems. Lack of public transportation, travel distances, and difficult terrain are often obstacles to mental health services in less densely populated rural and even more sparsely populated frontier areas. Questions have been raised about whether providers who are available are also adequately trained to deliver culturally sensitive, age appropriate care to different groups residing in these communities. Cultural barriers may exist to the extent that rural America is diverse, especially across regions, and reflects different values and lifestyles than urban America (NIMH, 2002).

Part One: Enhancing Supply of Mental Health Providers in Rural Populations

Mental Health Professional Shortage Areas

By federal definition of mental health professional shortages, rural areas disproportionately suffer from a shortage of mental health providers. In 1999, 87 percent of the 1669 Mental Health Professional Shortage Areas (MHPSAs) in the United States were in non-metropolitan counties and home to over 30 million people (Bird et al., 2001). Twenty percent of non-metro counties lack mental health services; the same is true in only five 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 (Goldsmith, Wagenfeld, Mandersheid, & Stiles, 1997;

Hartley, Bird, & Dempsey, 1999). Moreover, fewer rural hospitals than urban ones offer inpatient psychiatric services (Hartley et al., 1999).

Probably the greatest difference in mental health services in rural and urban areas is the availability of and accessibility to specialty mental health services. Although the supply in specialty mental health professionals has shown substantial growth in the number of mental health specialists nationwide during the 1990s, the increase was minimal in rural areas (Goldsmith et al., 1997). Among rural counties with populations between 2,500 and 20,000, nearly three-fourths of lack a psychiatrist, and 95 percent lack a child psychiatrist. Only about 52 percent and 42 percent of these counties, respectively, have a psychologist or social worker, trained at the master's level or above, residing in the county, and working in health the health care field. The supply of all of these professionals is far lower in the 769 counties with fewer than 2,500 people (Holzer, Goldsmith, & Ciarlo, 1998).

Securing designation as a Mental Health Professional Shortage Area (MHPSA) can trigger national and state loan repayment programs. The goal of such programs is to attract mental health professionals to rural areas. Moreover, states are allowed to include clinical psychologists, clinical social workers, psychiatric nurse specialists, and licensed marriage and family counselors, along with psychiatrists, in designating mental health professional shortage that qualify for the recruitment incentive programs. Despite these Federal policies designed to increase the availability of mental health services, state scope of practice laws and reimbursement rules sometimes further reduce the availability of mental health services. For example, scope of practice rules or reimbursement policies that do not accept particular services being provided by masters-trained professionals may disadvantage rural areas where psychiatrists or psychologists with doctoral training are in shorter supply (Bird et al., 2001).

Seeking designation as a Mental Health Professional Shortage Areas (MHPSAs) in order to attract mental health professionals to rural areas can be advanced by making information on current supplies and locations of mental health professionals more complete, accurate, and available. A careful analysis of MHPSA measurement issues and mental health manpower needs has resulted in numerous recommendations to meet information needs and to otherwise address related credentialing, licensing, and other mental health manpower responses (Bird et al., 2001).

> **Recommendation 1. National and state governments should join forces to make information on the current supply and location of mental health professionals more complete, accurate, and accessible to support recruitment efforts in rural areas.**

Training and Recruitment of Specialty Mental Health Providers for Rural Areas

The provision of mental health services in rural areas is often dependent upon a small collection of specialty mental health providers (where available), primary care

physicians, rural hospitals, nursing homes, schools, social workers, counselors, ministers, law enforcement personnel, self-help groups, family members and friends.

Provider shortages have an impact on treatment. Depression treatment for people in rural Arkansas is hindered by both provider numbers and distance (Fortney, Rost, & Warren, 2000). Rural individuals with depression confront a significantly smaller supply of general medical and specialty care providers to choose from than do their urban counterparts. Specifically, Rost et al., 1999 found in their study that there were 551 general medical providers within 30 miles of urban individuals compared with 48 for rural individuals. Similarly, there were 178 mental health specialists within 30 miles of urban individuals compared with nine for rural individuals (Rost, Fortney, Zhang, Smith, & Smith, 1999).

In a Maine study, rural Medicaid beneficiaries are less likely than urban ones to have an outpatient mental health visit in a year's time, those with visits have fewer mental health visits per year, and rural disparities in inpatient visits are even more pronounced. The rate of rural Medicaid use of mental health services (one-half the rate in urban areas) was linked to a relative lower supply of mental health providers in rural areas. (Lambert & Agger, 1995). Similar lower rural utilization of mental health providers is found in a study of a commercially insured population in Maine (Hartley, Agger, & Miller, 1998a).

The Ad Hoc Rural Mental Health Provider Work Group (Pion, Keller, & McCombs, 1997) has made recommendations to address the supply of rural mental health professionals:

- Develop rural health focused didactic and experiential training for mental health graduate students;
- Recruit rural-connected individuals into graduate training programs in the mental health disciplines;
- Increase training-related placement of mental health students in rural areas to increase the supply and effectiveness of rural mental health providers and improve consumer access;
- Incorporate training support activities for behavioral health services into area health education centers; and
- Provide Federal and state funds to train rural mental health professionals.

Most states fund programs to increase the supply of rural health professionals through either loan repayment or scholarship programs. Both programs require a length of service in a rural area in exchange for tuition payment. Most states use the Federal Health Professional Shortage Area designation to determine where to place practitioners. Some states require training in rural practice for health care professionals in hopes that the exposure will increase the number of graduates who choose to serve rural communities. Other approaches such as recruitment fairs and paid recruiters, income tax credits, malpractice premium discounts, and locum tenens programs (providing professional relief to practitioners) are used to encourage practice in rural areas (Slifkin, 1999).

<u>Recommendation 2.</u> The number and training of rural mental health providers should be increased through multiple methods: a) rural-focused training for mental health graduate students, b) recruitment of rural-connected individuals into graduate training programs, c) training-related placement of mental health students in rural areas, d) provision of continuing professional education in area health education centers, e) innovation in reducing professional and social isolation in rural practice, and f) provision of additional governmental funding for training of rural mental health professionals.

The Role of Primary Care Physicians in Mental Health

Only availability of primary care physicians appears to present some degree of parity between the most rural counties and the other rural counties with more than 20,000 population. However, large proportions of the most rural counties, those with less than 2,500 population, do not have a family practice physician (absent in 32 percent of such sparsely populated counties adjacent to metropolitan areas and in 41 percent of those nonadjacent). This condition exists in less than 6 percent of the counties with larger populations (Holzer et al., 1998). This finding suggests that approximately one third of these smallest counties may not have any of these professionals available locally to provide mental health services and that a large percentage of small counties may have no immediate available choice for professional mental health services beyond the local physician.

Rural people are more likely than urban ones to use primary care practitioners for mental health needs. Therefore, physicians who practice in rural and frontier areas play an even larger role in mental health care than their urban counterparts (Geller, 1999). This may be attributed to the scarcity of mental health professionals (Wagenfeld, Murray, Mohatt, & DeBruyn, 1994) and the stigma-associated reluctance to see a mental health professional (Haley et al., 1998; Rost, Smith, & Taylor, 1993).

There is recognition that the primary care physician is a major source of mental health care in rural areas. From 10 to 20 percent of rural patients rely on primary care physicians annually for mental health services and primary care providers see the majority of patients who seek such services (DeGruy, 1996; Ivey, Scheffler, & Zazzali, 1998).

Although some studies find reason for confidence in primary care providers' treatment of the mentally ill (Rost et al., 1999; Rost, Fortney, Fischer, & Smith, forthcoming), a number of researchers indicate concerns about deficiencies of primary care providers in treating the mentally ill (Rost, Smith, Matthews, & Guise, 1994a; Rost, Williams, Wherry, & Smith, 1995; Mechanic, 1997; Wells, 1996).

Treatment of mental illness by primary care practitioners faces a number of practice and professional constraints such as:

- insufficient mental health training in medical school or residency (Geller, 1999; Lambert & Agger, 1995);
- limited time for additional education required for managing challenging cases (Rost et al., 1999);
- insufficient skills in mental health (Lambert & Agger, 1995) and failure to detect a mental disorder (Schulberg, 1991);
- heavy patient case load (Geller, 1999; Lambert & Agger, 1995) with shorter visits with patients (Geller, 1999);
- lack of time for counseling and related therapies (Geller,1999);
- lack of specialized backup (Rost et al., 1999).

Even when specialized mental health professionals are available for possible referrals, there appear to be a number of obstacles to primary care physicians making such referrals:

- idiosyncratic standards regarding when to refer patients to a mental health specialist (Geller, 1999);
- stigma and concerns about the patients' acceptance of the diagnoses and future impact on insurability (Sussman, Crabtree, & Essink, 1995).
- patient reluctance to use mental health providers (Hartley et al., 1998a)
- lack of available specialist services (Hartley et al. 1998a; Lambert & Agger, 1995)
- long waiting times for appointments (Hartley et al., 1998a; Rost, Humphrey, & Keller, 1994b)
- primary care physicians' bad experiences with psychiatrists (Geller, 1999)
- lack of communication from referral mental health specialist inhibits physician's ability of follow-up (Haley et al., 1998).
- disagreement with psychiatrist's concern for confidentiality impeding necessary information sharing to enable the referring physician to work with patient (Geller, 1999)
- primary care physician distrust or dislike of psychiatrists (Geller, 1999)

Researchers find that some primary care physicians deliberately underdiagnose mental illness (Rost et al., 1994a). Rural family physicians may be able to detect depression, but may be reluctant to make such formal diagnoses because of stigma, doubts about the patient's acceptance of a mental disorder diagnosis, or a concern for the patient's future insurability (Sussman et al., 1995; Rost et al.,1994a). Coding of patient visits may be adjusted in some instances to allow for reimbursement for care that would not be reimbursable to the provider in question if the more accurate code were recorded (Rost et al., 1994a). Those unwilling to miscode diagnoses could discontinue treating patients with mental illness, especially if mental health benefits are carved out.

A study of rural Maine Medicaid beneficiaries and their use of mental health services from primary-care providers concludes that attempts to increase the supply of primary-care providers and train them to diagnose, treat, or refer mental health problems

(such as in the recent AHCPR Depression Guidelines) make sense in rural areas (Lambert & Agger, 1995). Proposals to strengthen the ability of the primary care providers to offer mental health services include improving the competency of primary care providers through clinical practice guidelines, utilization of screening instruments, and creating greater contact of primary care providers with mental health professionals via a variety of linkages (Geller, 1999).

Various programs and models have been developed to strengthen the role of primary care physicians in providing mental health services. The Robert Wood Johnson Foundation (RWJF) is funding a five year grant, Depression in Primary Care: Linking Clinical and System Strategies, that aims to increase the use of effective models for treating depression in primary care settings in urban and rural settings. A major component of the grants program will focus on training primary care physicians in treating patients with depression ("Depression," 2002; L. Hough, personal communication, May, 2002).

The University of Nebraska Medical Center developed two programs funded by HRSA in 1999 to improve behavioral pediatric services and to integrate mental health in primary care in rural areas. Both programs serve a radius of about 100 miles of surrounding towns. The first program involves an interdisciplinary training program and places post-doctoral students and interns in rural communities. The second program sends psychology faculty members from the University of Nebraska to sites to train and alleviate caseloads of primary care physicians providing mental health services (J. Evans, personal communication, March, 2002).

> **Recommendation 3: Medical school training, residency training, and continuing medical education, including major efforts within Area Health Education Centers (AHECs), must be directed at strengthening the ability of rural primary care providers to treat basic mental health needs.**

Linkages between primary care and mental health professionals

Improving the link between primary care providers and mental health specialists is of major interest among authorities on rural mental health (Bray & Rogers, 1995; Haley et al., 1998; Mohatt, 1995; Lambert & Agger, 1995; Pruitt, Klapow, Epping-Jordan, & Dresselhaus, 1998). One study identifies four models linking primary care providers and mental health professionals based upon the examination of 53 primary care organizations in 22 states (Bird et al., 1998):

- Diversification - primary care organization or physician hires mental health personnel to offer services at the primary care site;
- Linkage - primary care organization enables MH personnel independent of the primary care organization to offer services at the primary care site;
- Referral - arrangements for patients of primary care providers to use off-site mental health providers;
- Enhancement - additional training for primary care providers to diagnose and treat mental health patients.

Linkage and referral appear to be the most frequently employed linkage models. Still other models of collaboration across primary care and mental health care providers have included such activities as co-location, facilities sharing, joint staff activities, and the like (Sorensen, 1999). Co-location (or integration) reduces the barrier of stigma and enhances the probability of receiving appropriate care.

The respective roles of primary care physicians and mental health specialists in coordinating efforts continue to be discussed. Given the reliance upon rural primary care physicians, it has been argued that rural physician leadership is essential to the integration of psychosocial services and mental health professionals in individual, family, and community contexts (Badger, Robinson, & Farley, 1999). At the same time, the concern that doctors may miss mental health or substance abuse diagnoses has led to advocating consultant relationships between mental health professionals and physicians to address both diagnosis and treatment problems (Slay & Glazer, 1995; Bird et al., 1998).

National Rural Health Association recommendations in May 1999 called for additional funding for interdisciplinary training to foster linkages among rural primary care, mental health professionals, and other rural mental health providers (National Rural Health Association [NRHA], 1999). Much of this training should be community-oriented, focused on cultural competency, and provided in rural community settings.

A number of initiatives are pursuing improved screening for or treatment of depression in primary care settings. The U.S. Preventive Services Task Force and Agency for Healthcare Quality and Research issued guidelines in May 2002 encouraging primary care clinicians to screen their adult patients for depression ("Screening," 2002). The Bureau of Primary Health Care is encouraging FQHCs to adopt disease management programs that address depression. The Robert Wood Johnson Foundation program promoting use of effective models for treating depression in primary care settings was mentioned above. And, at least one, large rural integrated delivery system, is conducting depression screening at its rural primary care clinics on each of its health plan patients who are enrolled in any of its various disease management programs (J. Sidorov, personal communication, March, 2002).

Managed Behavioral Health Care organizations are expected to link a variety of providers in meeting the mental health needs of its enrolled population. The success of such health plans may be advanced by capitalizing on linkages--where they exist--between primary care and specialty mental health providers. These efforts may be blunted where relations among these provider types have been strained. Success may be found, too, in allowing for variation across regions in delivery system arrangements, including those comprised of a mix of county and other public and nonprofit provider organizations and professionals in the delivery of rural mental health services (Lambert, Gale, Bird, & Hartley, 2001; and Mohatt, 1997).

Alternative approaches that take on techniques of managed care but have different organizational goals and objectives are needed. For example, community based health

organizations or providers might become better informed about available Federal and state resources that, although seemingly unrelated, can be applied to providing social, physical and mental health services to rural residents. Such organizations can serve as an agent which addresses comprehensive mental health needs of rural residents. The precedence set by the PACE (Program for All inclusive Care for the Elderly) as an agent for elderly (Center for Medicare and Medicaid Services, 2002) can be a model for developing an agent for the rural mentally ill.

Such an agent may be established within primary care practices that are integrated with mental health services. As rural primary care practices provide an even greater proportion of mental health care than their urban counterparts, due to the scarcity of psychiatrists and other mental health specialty service providers in rural areas, primary care practices may be an ideal place for this agent for comprehensive care for the mentally ill. Similarly, FQHCs might be a base for such integration of mental health services and primary care.

Successful integration of mental health services into a primary care organization is not a simple matter. It requires attentiveness to the views of communities, professionals, and patients regarding stigma, confidentiality, and preferred treatment modalities. Of professional and organizational import, too, are implications for documentation, billing, and finances of the primary care organization (Farley, 1998).

Several types of local health centers are key players in mental health. Community mental health centers (CMHCs) remain an important source of mental health services in many rural areas. A recent study suggests that mental health center services to the poor may be advanced by regulatory and financing changes promoting ties with primary care providers and health networks (Lambert & Agger, 1995). Similarly, increased availability of non-doctoral level psychologists and social workers, supported by appropriate licensure and reimbursement provisions, could enhance CMHC staffing (Lambert & Agger, 1995). Some Medicaid Managed Behavioral Healthcare (MMBH) arrangements have been creative in including CMHCs in networks of providers and some CMHCs and primary care providers have been effective in sharing scarce mental health professionals.

One study (Abrams, Savela, Trinity, Falik, & Tutunjian, 1995) of seven health center sites in rural and urban underserved areas contracting with managed care suggests that mental health services may suffer within such MMBH arrangements. Specific panel restrictions imposed by an HMO may require switching to new and unfamiliar mental health providers who are often geographically inaccessible to the center's Medicaid population.

Rural facilities assured of some degree of continuing Federal funding, e.g., FQHCs or critical access hospitals, may be in a position to provide or otherwise facilitate through rural health networks or other means the provision of essential mental health services in their respective rural communities.

<u>Recommendation 4.</u> Federally Qualified Health Center (FQHC) program initiatives, Medicaid, and other federal and state programs, such as interdisciplinary training, should support linkages between primary care and mental health professionals.

Alternative Mental Health Providers

Extending the focus beyond psychiatrists, child psychiatrists, and master's-level psychologist and social workers, there is evidence of a rapid increase nationally in the supply of several other types of clinically trained mental health professionals. Among these are counselors, marriage and family therapists, and school psychologists (Peterson et al., 1998). These professions may play an important role in mental health for adults (e.g., family therapists encountering depression) and children (school psychologists conducting assessments and interventions). This role may be especially important in the absence of those professionals with more indepth training in psychiatry or psychology. Although rural-urban distributions for these professionals are not reported, wide variations in the numbers of these professionals across the states suggest that the availability of these professionals, too, may be more limited in rural areas (Peterson et al., 1998).

Rural populations' increasing reliance upon non-physician primary care providers for medical care may offer less benefit to those suffering from mental illness. Among primary care providers, nurse practitioners and physicians assistants, according to one study are less likely than primary care physicians to see patients with depression, to prescribe antidepressants, or to treat such patients without referral (Hartley, Korsen, Bird, & Agger, 1998b).

Increasing attention is being given to expanding the role of existing professionals to meet the mental health needs. On July 1, 2002, psychologists in New Mexico gained authorization to prescribe psychotropic medications to their patients. These psychologists must be licensed, doctoral-level psychologists who have completed an additional training and certification program consisting of 450 hours of course work, 400 hours of training, and successful completion of a national examination. The new law is intended to provide greater access to quality care at lower cost. Many mental disorders have optimal success when treated through a combination of psychotherapy and medication. This new law enables the patients to receive care from the same mental health professionals increasing efficiency and decreasing costs (Goode, 2002).

State and/or county-funded and delivered mental health programs, state fee-for-service program, and state-supported managed behavioral healthcare initiatives must recognize the diversity that exists across rural areas and enable regional or local organizations to tailor programs to local conditions. This includes, in some instances, providing training-in-place for professional and nonprofessional caregivers who are currently providing services to the mentally ill. Careful evaluations of these initiatives are needed.

Various disease management programs turn over more responsibilities for depression management—screening, medications management, and related activities—to nurses and other health professionals functioning under the authority of a physician. Such programs, once largely the province of health plans, are becoming more prevalent in large health systems and small FQHCs, as well.

Parallel to improving cultural competency of mainstream-trained providers, integrating traditional healers and alternative medicine providers could be beneficial. As community needs assessment among Native American communities has consistently identified, having traditional native healers in treatment teams is preferred (Circle of Care, 2002). Community based epidemiological survey of Chinese Americans also show a significant use of traditional Chinese medicine practitioners (Tai-Seale, 2002). Empirical evidence of therapeutic benefits of these patient-preferred traditional providers should be rigorously gathered. It will not be unreasonable to expect such benefits to be real in light of recent findings on placebos being more effective in treating major depression in comparison to St John's Wart and a SSRI ("Hypericum," 2002).

Recommendation 5. States should consider well-designed and carefully evaluated modifications to their scope of practice limitations, in combination with requiring additional advanced training relevant to any newly authorized practices, to enable additional health professionals to provide quality mental health services in areas in which psychiatrists are in scarce supply.

Telemental health

Telemental health is another means of bringing mental health services to remote, or otherwise underserved, rural populations. A nationwide survey of telehealth networks to assess the extent and character of telemedicine activity in rural areas noted that the number of mental health telemedicine networks more than doubled between the years of 1996 and 1999, increasing from 25 to 55 (Grigsby, 2002). Of the five specialty networks surveyed, mental health networks are the most prevalent and have shown the greatest increase in number. The total number of mental health teleconsultations grew from 2,886 in 1996 to 11,974 in 1998 and were projected to increase to almost 16,000 in 1999.

Positive experiences are being reported from recent efforts with telepsychiatry, i.e., with direct encounters between psychiatrists in urban settings and patients in remote locations (Johnston & Jones, 2001; Rohland, 2001). A recent study suggests that both providers and clients value the additional interpersonal connection that video-conferencing provides and that relatively inexpensive video-telephone based approaches can support this connection (Cukor et al., 1998). Focus groups of patients and providers from frontier areas suggest overall positive assessments but note that a few patients are uncomfortable with seeing themselves "on TV" and/or prefer more familiar surroundings than a studio arrangement (LaMendola, 2000a).

At the same time a number of telemental health networks have been successful over a number of years, networks that have various included a direct psychiatric encounters, training, crisis response, medication management, and/or other components associated with admission, commitment, or discharge activities (Brown, 1998; Hartley, Britain, & Sulzbacher, 2002). Most of the frontier area telemental health applications have been developed by large medical school and hospitals, often with the use of Federal funds (LaMendola, 2000b). This suggests that these services remain dependent upon subsidization from outside sources and may not be fully integrated into day-to-day mental health services delivery. Moreover, rural frontier access to affordable telephone technology (not to mention higher speed internet access) remains a significant challenge with major companies divestiture of unprofitable rural service lines and much higher than normal cost to create and maintain the telecommunication systems essential for telemental health (LaMendola, 2000b).

More generally, telehealth remains an important option for providing training, consultation, and support to rural primary care providers in the face of continued rural shortages of mental health specialty providers (Rost, Owen, Smith, & Smith, 1998) and for more specialized training for other professionals and paraprofessionals. Despite the high costs in rural areas, pursuit of telemental health options are likely to continue as a response to the severe rural shortages of mental health specialty providers (LaMendola, 2000b).

A number of successful models of telemental health have served rural areas for a number of years. A few are singled out here.

The University of Kansas Medical Center started a telemedicine program including psychiatry for all age groups in 1991. What became the most active child and adolescent telepsychiatry clinic in the telemedicine program began in 1996 as a collaborative effort of the Medical Center and the Crawford County Mental Health Center, located 120 miles from the Medical Center. The clinic saw more then 1,000 patients in the first two years. The Mental Health Center contracts with a psychiatrist located at the medical center on an hourly bases and delivers telepsychiatry services to patients seen by nurses and determined to be in need of the service. Mail and fax are relied upon to exchange information before and after the televideo encounter, including assessments, records, medication and laboratory orders, recommendations and other information. The clinic has been able to provide services successfully to children with serious and complicated mental illness and treats children in crisis situations safely at least once every two weeks. Children's symptoms improve through telepsychiatry interventions just as they would through face-to-face clinical interactions (Ermer, 1999).

The Northern Arizona Regional Behavioral Health Authority (NARBHA) began in 1996 to develop a telemedicine system designed to deliver mental health services throughout 62,000 square miles of northern Arizona through funding from the Arizona Department of Health Services. Between 1996 and 2001, over 7,900 telemental health services were delivered via videoconferencing. Both patients and staff report positive experiences with the system. In addition to direct provider-patient psychiatric services,

NARBHA net provides regular training, case consultation, administrative meetings, case management, discharge planning and client staffing between its fifteen sites. The system offers many benefits including: improved access, patients treated in their own communities, increased physician continuity, decreased professional isolation, and increased family involvement. NARBHA has received recognition as one of the Top 10 Telemedicine Networks in the U.S. by the Telehealth magazine in 1997, 1998, and 1999 (Northern Arizona Regional Behavioral Health Authority, 2002).

Beginning in 1995, Appal-Link, The Southwestern Virginia Telepsychiatry Project began providing clinical and support services with funding from the Federal Office of Rural Health Policy. In its first two years, the Appal-Link Project delivered psychiatric care to 263 patients involved in 820 clinic appointments. Daily services include medication management, case consultation, discharge planning, commitment hearings, family visits, and staff training. The Appal-Link network includes ten sites throughout Virginia. It is the only telehealth network of the top ten in the nation that operates solely on mental health applications, and unlike most telehealth projects, is not university or medical center based. After six years of operation, the Appal-Link network has provided 853 patients with telemental health services and delivered 1,743 hours of tele-medication management clinics. The Appal-Link network has found that consumers become very comfortable with and accept these services ("Appal-Link," 2002).

Eastern Oregon's RodeoNet has been operating since 1991 and is currently reported to be self-sustaining and is achieving its mission of enhancing communication between providers and ensuring better distribution of specialist mental health care. A key to the success of RodeoNet is through Oregon's Video and Online Services Network – a public system that shares the operating costs among its participants. The direct costs of consultations have been reported to be up to fifty percent less than face-to-face consultations (Brown, 1998; K. Campbell, personal communication, April, 2002).

Limitations in telemental health include the issue of physician licensing across states and patient consent for use of the telemedicine equipment. However, telemental health has the potential to be a cost-effective solution for rural areas while providing much needed mental health care.

Recommendation 6. Support for telemental health in rural areas should be sustained and evaluated as Federal and state governments and private payers address reimbursement, cross-state licensure, telecommunications technology, and other issues.

Part Two: Access To Mental Health Services For Rural Populations

Compounding the shortage of mental health professionals, a number of other challenges face rural populations seeking to access mental health care. Some rural subpopulations appear to be particularly disadvantaged in accessing care. Lack of transportation and stigma issues are other important barriers for rural individuals who need mental health care.

Women, the elderly, and children

Rural women may experience more mental illness but underutilize mental health services (Shelton, Merwin, & Fox, 1995). Although rural women are at great risk for depression and stress-related disorders, these conditions are less likely to be diagnosed by rural practitioners (APA, 1999). According to a Virginia community health center study, rural women are twice as likely as rural men to be depressed. Factors associated with depression among women at this center include motherhood, age, race, single parenting, education, poverty, and unemployment (Hauenstein & Boyd, 1994).

Elderly adults may face particular challenges in accessing mental health services. Although an estimated 15 to 25 percent elderly suffer from mental disorders, only two to four percent of mental health professionals' practice time is spent with elderly clients. Unfavorable reimbursement and patient perception of provider reluctance, are among possible reasons for such apparent underservice of the elderly (Dellasega, 1991). The nursing home picture, urban and rural, appears even less favorable to mental health treatment. Although two-thirds of elderly nursing home residents suffer from a mental disorder, less than 5 percent receive a mental treatment within a one month period (Burns et al., 1993). A recent study in Maine, noting the greater tendency of rural elderly with serious and persistent mental illness to rely on primary care physicians, raises questions about the ability of rural primary care providers to manage such complex cases (Lambert, Hartley, Bird, Ralph, & Saucier, 1998).

In rural areas, evidence suggests that children with serious mental health problems are particularly disadvantaged in terms of having their care needs met (Wolff, Dewar, & Tudiver, 2001). Children with mental illness receive mental health care from a variety of sources, and rural children are less likely to use these services. Typically, children with mild mental health problems might be served by a loose network of physicians, school counselors, mental health workers, and child protective caseworkers (Burns et al., 1995; Waggenfeld et al., 1997). Schools may have become the de facto mental health provider for most rural children. The lack of specialized mental health professionals and facilities in rural areas is more problematic for children with serious emotional disturbances. Advocates for severely emotionally disturbed children and adolescents have call for a comprehensive, coordinated network of mental health and other necessary services to meet the changing needs of these children (Johnsen, Morrissey , & Calloway, 1996).

Wraparound services models are pursued in a number of states to serve children and their families. In some instances, there is a heavy emphasis on case management with extensive coordination with available mental health resources in the community. The focus may be to identify with the family their strengths, needs, and goals and to plan how to reach the goals. Such a plan may call for in-home therapy by a local mental health therapist and other supportive services. In other instances, a family resource developer may work with child development specialists, the parents and children, and with others in the community who work with children to educate them about children's mental health issues (Simpson et al., 2001).

Recommendation 7. Within rural areas, women, the elderly, and children or other groups who may be particularly vulnerable to untreated or under-treated mental illness should be considered as target groups for whom special programs may be appropriate.

Special populations - ethnic and cultural minorities in rural America

Very little is known about rural minority population's mental health status, or their access to care. Very few studies focus on mental health among rural minority populations. In this section, we draw from the larger literature on mental health of ethnic and racial minorities that are relevant to their rural members.

Presence of minorities in rural America - African American and Native Americans are the two minority populations with significant presence in rural America African Americans are overrepresented in the South, especially in impoverished rural areas. Hardship in these communities is notable. Disparities in economic resources, institutionalized racism, lack of safety net providers for primary care or mental health specialty care all translate into heavy mental illness burdens on rural African Americans (Fox, Merwin, & Blank et al., 1995). About 42 percent of Native Americans live in rural areas (Rural Policy Research Institute, 1999). One in five Native Americans live on reservations and on trust lands, and more than half live in urban, suburban, or rural nonreservation areas (DHHS, 2001). Over half of the Latino population in the country resides in California and Texas (DHHS, 2001), with areas bordering Mexico that are mostly rural with no or only primitive infrastructure. Despite the rapid population growth in the Latino population, very little is known about the mental health of rural Latinos. Though the majority of Asian Pacific Islanders reside in large metropolitan areas on the U.S., refuges from Laos, Cambodia, and other Southeast Asian countries make their homes in various rural communities.

Cultural-bound expression of psychopathology – Populations with strong cultural identifications – e.g., Native Americans, African Americans, Latinos, and Asian Pacific Islander refugees – have different explanatory models of diseases. Socio-cultural and linguistic traditions significantly affect mental illness detection and perceived treatment. While there are 561 federally recognized Native American tribes, over 200 indigenous languages are spoken (Fleming, 1992). Approximately 280,000 Native Americans speak a language other than English at home (DHHS, 2001). Asian Pacific Islanders speak over

100 language and reports from the 1990s indicate that 35 percent Asian Pacific Islanders live in linguistically isolated households where no one age 14 or older speaks English "very well" (DHHS, 2001). Likewise, in the 1990 Census, about 40 percent of Latinos reported they either didn't speak English or didn't speak English well (DHHS, 2001). Cultural differences in the expression and reporting of distress are well established among Native Americans and Alaska Natives. Words such as "depressed" and "anxious" are absent from some Native languages (Manson, Shore, & Bloom, 1985). Severe emotional disorders are often referred to as being "out of balance" or "out of harmony" (P. LeMaster, personal communication, March, 2002). Ethnographic work reveals other examples of unique expression of distress, e.g., *ghost sickness* and *heart break syndrome* (Manson et al., 1985).

Similarly, Southeast Asian cultures tend to interpret psychosocial or psychological symptoms as manifestations of physical disorder and therefore present somatoform symptoms (Lin et al., 1992; Mollica & Lavelle, 1988). Likewise, in some Latino subcultures, emotional disturbances are viewed as both precursors to and consequences of physical disease (Escobar, 1987).

Such culture-bound interpretations of physical manifestations of psychiatric disorders may prove difficult for practitioners grounded in western technology-based medical mindset (Waitzkin, 2001). The divergence of western modern technology based medicine and "ethnomedical" explanatory models rooted in cultural contexts often creates tension as practitioners fail to take into account patients' understanding of illness as embedded in spiritual forces, supernatural processes, or other culturally shaped events (Waitzkin, 2001).

Rates of psychopathology – Rates of psychopathology among minority populations have been difficult to assess. Estimates based on utilization rates among clinical samples can seriously underestimate the actual need because minority, rural residents in particular, under-use mental health services (Rost et al., 2002) or have mislabeled diagnosis (Rost et al., 1994a). However, surveying a more representative sample of minority populations is very costly and so is seldom conducted, especially among rural special populations. Moreover, it is not known to what extent Western diagnostic criteria may overlook cultural-specific symptom expression and culture bound syndromes.

Among several studies that have reported rates of known psychiatric disorders based on psychiatric inventories rather than utilization rates, high prevalence and severity levels were found among Native American and Alaska Natives (DHHS, 2001), Asian Pacific Islander Americans (APIA) samples (Sue, 1994), Latinos and African American (DHHS, 2001). Although relatively little evidence is available, the existing data suggest that Native Americans and Alaska Native youth and adults suffer a disproportionate burden of mental health problems compared with other Americans. The high suicide rates documented among some segments of this population further suggest the need for culturally appropriate mental health services (DHHS, 2001).

Access to mental health care is a problem in the U.S.-Mexico border region due to both a shortage of specialty mental health providers and culturally competent providers. While little is documented on the prevalence of mental illness in the Mexican-American population, suicide rates can serve as indicators to mental health. In 1998 there were nearly 1,600 suicide deaths in the border region, with about 1,300 in the United States compared with about 250 in Mexican. Even though suicide death rates have declined in the border region over the past ten years, the suicide death rate for the U.S. border has remained equal to or slightly above the national rate especially for those 75 years and older (Healthy Borders, pre-publication).

These data concur with findings of increased symptoms and disorder rates the longer one lives in the United States after emigrating from Mexico. Rates of psychiatric morbidity are significantly lower among immigrants: 24.9% compared with 48.1% in U.S.-born Mexican Americans (Vega et al., 1998). The study found considerable differences in utilization rates and type of provider between urban and rural Mexican Americans. Rural Mexican Americans were more likely than urban Mexican Americans to seek help from the primary care sector and from informal care providers and were less likely to utilize mental health specialty care. In addition, utilization rates of foreign-born residents of the U.S. were two-fifths that of U.S.-born residents across all sectors of care. A notable explanation for lower utilization of mental health services is based on the belief that strong support systems somewhat displace the need for formal care providers (Vega, Kolody, Aguilar-Gaxiola, &Catalano, 1999).

Without population-based survey data, we can only infer that rural minority populations are not too different from their urban counterparts in prevalence and severity levels and in under-use of services. Though major community-based epidemiological studies (e.g, National Comorbidity Study, and the ECA) have documented that the prevalence rate for mental illnesses are similar between rural and urban populations, we must exercise caution when interpreting such epidemiologic findings. Minority patients – African American in particular – are over-represented in inpatient mental health facilities and prisons (Snowden & Cheung, 1990; Beaux & Ryujin, 1999). Rural residents are also hard to access for researchers conducting community-based surveys. Therefore, community-based epidemiological studies are likely to under-report prevalence in rural minority populations.

Use of treatment services - In addition to shame, stigma, and misconception about mental illness, lack of knowledge about alcohol and substance abuse as mental illnesses and about effective treatments that are available makes one less likely to seek care which, in turn, can prolong suffering. Blacks and rural residents are found to underutilize mental health services and seek help at more advanced stages of the disorder (Blank, Tetrick, Brinkley, Smith, & Doheny, 1994; Fox, et al., 1995). This, in part, explains why African Americans are over-represented in inpatient psychiatric facilities (Snowden & Cheung, 1990; Beaux & Ryujin 1999).

Even among those who have overcome the initial barrier to seeking care, additional barriers are encountered when they interact with the mental health care

providers, ranging from insensitive or rude intake clerk to physicians who do not recognize contextual factors. Substantial outright tension and miscommunication can occur and result in poor adherence to treatment regimens among ethnic minority populations.

Studies have found that African Americans and Asian Pacific Islander Americans are more likely than whites to prematurely terminate care (Sue, 1994; Wong, 1985; Sue, Sue, Sue, & Takeuchi, 1995). Additional studies show that fewer than half of Native Americans who were seen in outpatient mental health facilities returned after the initial contact, the highest non-return rate observed for African Americans, Asian, Latino Americans, and whites (DHHS, 2001).

Discrimination and racism – Persistent and unaddressed stress can lead to distress, depression or generalized anxiety disorders (DHHS, 2001). Minority groups frequently report experiences with racism and discrimination which are clearly stressful events (Clark, Anderson, Clark, & Williams, 1999). Many studies document the linkage between perceived racism and depression among African Americans (Kessler, Borges, & Walters, 1999), Asian American immigrants (Noh, Beiser, Kaspar, Hou, & Rummens, 1999), Mexican Americans (Finch, Kolody, & Vega, 2000) and children of immigrants (Rumbaut, 1994).

One study shows African Americans to be 2.5 times more likely to fear mental health treatment than whites (Sussman et al., 1987). African Americans were also more likely than whites to describe stigma and spirituality as affecting their willingness to seek help for mental illnesses (Cooper-Patrick et al., 1997). Rural African Americans often perceive psychiatrists and psychologists as representing the dominant culture (Fox et al., 1995).

Disparities in treatment of African Americans perpetuate historical injustice. For example, evidence of racial disparity in anti-depressant medication choice – African American Medicaid beneficiaries more likely to receive tricyclic agents (TCA) than selective serotonin reuptake inhibitors (SSRIs) than white beneficiaries – in a Southern state has been documented (Melfi et al., 2000). While African Americans are found to have slower metabolism rate of antidepressants and antipsychotic medications and might be more sensitive to these medications than whites (Bradford, Gaedigk, & Leeder et al., 1998), they are more likely to receive higher overall doses of neuroleptics than are whites (Walkup et al., 2000). The combination of such ill-prescribed treatment can cause severe side effects thus compromise the quality of care (Lin, Cheung, Smith, & Poland, 1997) and dignity of the patients.

Insurance coverage is one of the most important determinants for deciding to seek treatment among both African Americans and whites. It is clear that insurance alone, however, whether provided by private sector plans (Snowden & Thomas, 2000), by Medicaid (Melfi et al., 2000) or by Medicaid managed care plans (Tai-Seale, Freund, & LoSasso, 2001), fails to eliminate disparity in access or quality of care between African Americans and whites.

Preferences for culturally competent care – Under-use of formal mental health services may also be a reflection of ethnic minorities' preference for more culturally congruent care. For example, Asian Pacific Islanders prefer herbalist, acupuncturist, and other forms of indigenous healing (Wong, 1985). Navajo patients at a rural Indian Health Services clinic in New Mexico reported that 62% of them had used native healers and 39% reported using native healers on a regular basis (Kim & Kwok, 1998). Preference for traditional native healers to be part of the mental health treatment team has also been repeatedly expressed in recent surveys of Circle of Care grantees (Circle of Care, 2002). The scarcity of psychiatrists of Native American heritage – 29 in the US in 1996 (DHHS, 2001) – makes it necessary to expand the pool of culturally competent providers to native healers, or other paraprofessionals with native heritage. Many African Americans closely associate their mental health with spirituality and to some extent, their religious community and their churches (McBride-Murry, 2002).

Resilience and focus on prevention – Despite historical and perpetual hardship in their current lives, many minority groups are among the most resilient (DHHS, 2001). Initial efforts have been made to understand the strengths of various racial and ethnic groups' cultural and historical experiences so that new insights can be gained on how to prevent the emergence of mental health problems or reduce the impact of mental illness when it strikes (Thompson, 2001). Using public health approaches, research on resilience has found protective factors for mental health in racial and ethnic minority groups to include supportive families, strong communities, spirituality, and religion (DHHS, 2001).

While the need for culturally competent care is great, many minority members in rural American must rely on an increasingly stressed safety net of community health center, rural and migrant health centers, and community mental health agencies for physical and mental health care services (Institute of Medicine, 2000). A few promising practices are emerging to address the disparities in mental health experienced by ethnic and racial minorities.

Increased utilization, length of treatment, consumer satisfaction, and therapy outcomes have been attained by ethnic matching between therapist and patient (Takeuchi, Sue, & Yeh, 1995), culturally responsive care, flexible hours, community-based facilities, bicultural and bilingual staff, and implementation of culturally congruent treatment plans (Sue et al., 1995).

A variety of demonstration projects are underway. While few of them are designed for rural populations exclusively, many could have implications for improving mental health care for rural residents. For example, the Chinatown Health Center in New York City, a Health Resource Services Administration (HRSA)-funded community health center is participating in 2 demonstration projects. The first is a study whether it is more effective to treat older Chinese American patients with mental illnesses in an integrated primary and behavioral health program or to have the primary care physician refer them to specialty mental health services. The second project implements a quality

improvement program aimed at transforming the way the health center treats patients with depression.

Many federally funded projects are designed to assess community needs and assist program development among Native Americans and Alaska Natives. Majority of projects set prevention as a top priority with particular focus on promoting children's mental health and family preservation (Circle of Care, 2002). While a large number of projects have centered on alcohol and drug use, a growing number of programs are being designed and implemented with a specific mental health focus, typically suicide prevention (Manson, Beals, Dick, & Duclos, 1989; Duclos & Manson, 1994; Middlebrook, LeMaster, Beals, Novins, & Manson, 2001) and alcohol use prevention (Whitbeck, 2002). These interventions programs work under the auspice of tribal governments, employ native workers in program design and implementation (Whitbeck, 2002), and provide technical assistance to tribal initiatives (Novins, 2002). While many projects are still in progress, some earlier projects have shown significant promise, e.g., the Zuni Life Skills Development Curriculum (LaFromboise & Howard-Pitney, 1994) the Tiospaye Project on the Rosebud Sioux Reservation in South Dakota, which entailed organizing a series of community development activities that were cast as the revitalization of the *tiospaye*, an expression of traditional Lakota lifestyle based on extended family, shared responsibility, and reciprocity (Mohatt & Blue, 1982). Other projects also invigorated long-held tribal traditions to reduce situations of risk and to prevent mental illnesses, e.g., the Blue Bay Healing project among the Salish-Kootenai of the Flathead Reservation (Fleming, 1994) and the Western Athabaskan "Natural Helpers" Program (Serna et al., 1998). Many projects incorporate traditional ceremonies to raise community spirit and pride to relieve distress and prevent mental illnesses. Some held special healing ceremonies for mental health workers experiencing fatigue after extensive field work (Whitbeck, 2002).

Despite the painful history and myriads of socioeconomic challenges facing Native American and Alaska Native populations, many of them are resilient, able to thrive under severe adverse environments (DHSS 2001). The unique perspective of Native Americans on the notion of connectedness, reciprocity, balance and completeness underpins the contextual orientation towards health and well-being (Stokols, 1991). Their focus on harmony of the mind, body, and spirit, and their consideration of individual as well as collective strengths and means to promote mental health (DHHS, 2001) may very well teach all people – lay or professionals – of the fundamental aspects of health and well-being and prove valuable in promoting mental health.

Efforts to improve mental health care to minorities should include provision of affordable health insurance, but go beyond that to address the more fundamental issue of racial and ethnic equality in care delivery, from intake staff to physicians. Culturally competent services and service providers are needed. Practitioners and policy makers must take into account minority members' preferences in the formats and styles of receiving assistance.

Major changes in the financing and organization of mental health care are underway as a result of recent policies regarding self-determination (DHHS, 2001). Many innovative health promotion and disease prevention projects are underway with funding from the Federal government and technical assistance from research scientists. While it is possible that mental health services may be delivered increasingly more by native healers as it is a mechanism preferred by many Native Americans (Le Master 2002), the efficacy of alternative treatment has not been rigorously examined (DHHS, 2001). The methodological challenge will be to develop culturally appropriate conceptual models, measurements, and outcomes to facilitate evaluation of these approaches. The country as a whole has a great deal to gain by attending to advances in prevention among Native Americans and Alaska Natives, for the lessons learned in these communities may have broader application to all Americans (DHHS, 2001).

Under a contract with SAMHSA/CMHS, Sue and colleagues developed a set of recommendations to promote cultural competency to managed care organizations. Their recommendations are relevant to promoting cultural competency more broadly in rural mental health services:

- Development of rewards and incentives (e.g., salary, promotion, bonuses) for cultural competence performance, as well as sanctions for culturally destructive practices (e.g., discrimination) should be institutionalized in mental health services organizations.
- Cultural competence performance needs to be an integral part of the employee-provider performance evaluation system, and provider organization performance evaluation system.
- Programs should be in place for on-going program development which also identify gaps in service delivery for minority consumers and families, including consumer-run and alternative treatment programs.
- Procedures should be in place to maintain, recruit, and train culturally competent mental health service providers in primary care or specialty care settings.
- Performance-based reward system should be in place to promote successful achievement of performance standards which demonstrate effective service, equitable access and comparability of benefits for minority and other underserved populations. (Sue, Lee, Abe-Kim, Aoki et al., 1997)

Recommendation 8. Public and private mental health programs should promote cultural competency among mental health provider organizations and staff through recruitment, training, performance evaluation, incentives, rewards, and sanctions and, at the same time, identify unique strengths that might reside within special populations.

Indigenous Social Support and Coordination

Although the prevalence of lifetime and recent mental disorders appear to be similar in rural areas and in urban areas (Wagenfeld et al., 1994; Hartley et al., 1999; Kessler et al., 1994), rural residents with mental illness may be less likely than their

urban counterparts to define themselves as needing care (Fox, Blank, Berman, & Rovnyak, 1999; Rost et al., 2002). They are less likely, too, to report having several recent mental disorders (Kessler et al., 1994). Lack of knowledge of mental illness among rural individuals and their social support structure may be an important factor. Similarly, the role of indigenous caregivers in identifying and supporting the mentally ill persons in rural areas may not be fully realized.

The informal social network, smaller and tighter in many rural areas, may reduce anonymity for the person who needs mental health services. At the same time, however, a strong and supportive social network can move those who need help to seek it, and support them in that quest. Significant benefit might result from targeting this larger audience to identify mental illness and to help the mentally ill to recognize their illness and to seek help.

Interventions aimed at outreach and increasing perceived need for help among the mentally ill may be very important (Rost et al., 2002). Policies and programs are advocated to increase awareness of existing mental health services (Rost et al., 2002). Advertising (Ralph & Lambert, 1998) and general outreach and education can play a part. Interventions to increase "anonymity and acceptance of evidence-based treatment in rural America" are advocated, as well (Rost et al., 2002). Increased attention to cultural competence in the presentation of care in rural setting and to important sub-populations within rural settings must be part of such interventions (National Rural Health Association, 1999).

Sowing the Seeds of Hope: Responding to the Mental Health Needs of Farm Families is a preventative program designed to meet the mental health needs of the rural agricultural community in the mid-west spanning seven states. Sowing the Seeds of Hope provides behavioral health assistance to persons involved in agricultural business and the families of these persons. 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. The project leaders have identified core services emphasizing community support. These include 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, coalition building with organizations, agencies and communities, and retreats and support group activities for farm couples and families including financial planning. Integration of behavioral health care services into existing primary care and rural health clinics is being strongly encouraged. As farmers and ranchers visit their rural health clinics for medical care, it becomes easier for them to also obtain mental health and substance abuse services in the same facility. The program focuses on providing mental health services to the entire rural agricultural population by using outreach workers (members from the agricultural community), training providers (e.g. primary care physicians and clergy) to understand the unique characteristics of the agricultural population, support groups, and providing retreats for couples and families to learn about

stress management and financial planning (M. Rossman, personal communication, March, 2002).

A key difference between rural and urban area is associated with the number and types of providers available to offer mental health services in rural areas. There is also substantial diversities across rural and frontier states in the organization of mental health services for rural populations. These extend from those states such as Alaska which relies nearly exclusively on public mental health services to Arizona which relies on a managed care system with five nonprofit regional behavioral health authorities. Other states, e.g., Idaho, may rely on state and local public services in mental health, yet contract with a nonprofit organization for case management of SMI or, e.g., North Dakota, which relies on regions with public and private nonprofit collaboration. Alaska relies heavily upon village response teams, indigenous providers, and other, frequently grant-supported, approaches largely responsive to conditions in widely scattered remote villages (Wagenfeld, 2000).

A number of models, outside of managed behavioral health care, have been found to be promising approaches, many of them reducing mental health hospitalization. Among these is the “clubhouse” model, or more generally, “wellness models” for psychosocial rehabilitation, have been employed in selective rural areas in Virginia, Nebraska, and Idaho. These programs tend to emphasize a variety of meaningful activities in the community supportive of independent functioning and enhancement of self-worth and self-esteem (Wagenfeld, 2000). The Rhinelander Model, developed in Wisconsin, relies on nonprofessional, supportive caregivers to augment existing services. More specifically, companionship and monitoring functions are offered as these trained paraprofessionals unobtrusively guide the clients toward greater independence. As summarized in Wagenfeld (2000), the subtle dynamics associated with the latter goal, argue against using the same model for crisis intervention.

The closely related Citizen Companion program used in Idaho relies upon carefully selected caring nonprofessionals to provide support and advocacy for persons with SMI. Similarly, the Community Support model widely employed in rural and urban settings was evaluated in rural settings in Minnesota, Utah, and Idaho. Paraprofessionals were the lead persons in these programs with backup by social workers and psychologists. Wagenfeld (2000) reported that evaluations of these programs found not only lower hospitalization but greater acceptance of persons with SMI by the community.

A number of promising practices for children’s mental health are published each year with funding from the Substance Abuse and Mental Health Services Administration (Center for Effective Collaboration and Practice, 2002a).

Community Family Service Worker is a non-profit health consortium of several Native Alaskan groups that delivers mental health services--with an emphasis on isolation issues--on-site to several rural villages (as small as 100 residents) by using lay providers certified by the state of Alaska. The program provides training to improve mental healthcare skills and uses natural helpers in the community by providing training

and career development. The natural helpers are supervised by licensed mental health professionals who are in contact every 6-8 weeks by telephone, e-mail, fax, and telemental health technology (I. Greywolf, personal communication, March, 2002).

Informal caregivers among family, friends, or neighbors and natural helpers, such as local ministers or local sheriffs who are called upon in time of need or crisis may be important resources in rural communities. Paraprofessionals in the form of parish nurses or promotoras, for example, may be critical to linking clients with mental health service providers. The role of paraprofessionals may be critical in building relationships between local healers and mental health and medical professionals in some ethnic settings (e.g., among Native Americans). Programs that target informal caregivers, natural helpers, and paraprofessionals may be of particular importance in improving access to appropriate mental health services in many rural areas.

> **Recommendation 9. Programs should target community opinion leaders, natural helpers, paraprofessionals, and family members to educate rural people to recognize mental health needs and the efficacy and value of treatment.**

Stigma

A lack of anonymity in rural communities and the perceived social stigma associated with mental illness may prevent seeking of treatment (Calloway, Fried, Johnsen, & Morrissey et al., 1999). Regardless of reference to depression treatment by the general medical sector or specialty mental health sector, a recent study finds that rural individuals perceive less anonymity than do urban ones in such treatment (Rost, et al., 1999). Another study finds Iowa men and women living in small communities were more likely than those in larger ones to attach a stigma to mental health care (Hoyt, Conger, Valde, Weihs, 1997). Also, African Americans were more likely than whites to describe stigma and spirituality as affecting their willingness to seek help for mental illnesses (Cooper-Patrick et al., 1997).

Rural physicians may contribute to underdiagnosing of mental illness due to the perceived stigma associated with such diagnoses (Rost et al., 1994a). This behavior might reduce patients' pursuit of other mental health services that could be helpful.

A concern for stigma has also contributed to provider decisions to design services that involve co-location of mental health facilities with primary care. Co-location (or integration) reduces the barrier of stigma and enhances the probability of receiving appropriate care.

Samaritan Centers, broadly affiliated with the Samaritan Institute, provide faith-based counseling services at over 300 locations across the nation to approximately 500,000 persons per year. Many of the approximately 100 Samaritan Centers are located in urban areas; but many include service sites at affiliated offices in surrounding rural communities. Initially identified as pastoral counseling centers, many such centers

recognized the preferences of large numbers of people to seek mental health-related services in a faith-based setting. Such centers associated these services with the extension of the ministry and mission of a congregation and, for some, reduced stigma associated with seeking mental health services. Today large percentages of those providing care in these centers are licensed or certified professionals including many who are not pastors. The centers are affiliated with congregations and many of them gain efficiency from the use of church facilities for care provision throughout the week (Samaritan Institute, 2002; R. Ross, personal communication, March, 2002).

Many of these centers are approved providers with managed care and other insurance plans. A number of the clients of these centers are the working poor without mental health benefits. The centers also maintain referral arrangement with public agencies and with other specialist providers and facilities.

State mental health systems and managed behavioral healthcare organizations (MBHOs) should continually explore opportunities to contract with providers and other support organizations and professionals that can reduce the impact of stigma associated with treatment for mental illness while maintaining quality of service.

The barriers relating to stigma in seeking mental health care must be addressed. For example, co-location of mental health services and primary care or reliance on faith-based settings could improve access and utilization of mental health care. Moving the parking lot of mental health facilities (e.g. CMHC or FQHC) to the back of the building would also decrease stigma and shame associated with seeking mental health care.

Recommendation 10. State mental health systems, managed behavioral healthcare organizations (MBHOs), and other provider organizations should continually explore opportunities to contract with certain types of patient-preferred providers and use other mechanisms that can help reduce the impact of stigma associated with seeking and receiving treatment for mental illness.

Part Three: Financing Mental Health Care

Insurance barriers

For the United States as a whole, barriers that deter people from accessing effective treatment for mental illnesses are primarily insurance, availability and stigma. More than 44 million Americans are uninsured. Even those who have insurance coverage find mental health benefits much more restrictive than those for physical illnesses. Inequities in access to mental health services in rural and frontier populations, as well as the lack of mental health and health care services, have led members of Congress to urge both parity in mental health insurance coverage and greater parity in providing mental health services to rural and frontier populations (NIH 2002).

With the sunset of the 1996 Parity Act, there is uncertainty around the passage of comprehensive Federal parity legislation in the foreseeable future. There is evidence of renewed interest in mental health parity in the Administration and Congress. Also, more than 30 states have approved mental health coverage parity in some form.

The ongoing changes in health care systems associated with managed behavioral health care that emphasize cost containment could further impair access to mental health services for people in rural and frontier areas. In the effort to trim the health care costs, rural mental health services could continue to suffer disproportionately.

The scarcity of resources in rural communities is an overriding factor in the development of effective health care system for persons with mental illnesses. The care system is often provider-driven and crisis-oriented, lacking coordination and offers little opportunity for proactive or strategic planning (Topping & Calloway, 2000). While managed behavioral health plans have been documented to provide efficient services during acute episodes to the mentally ill, there is no clear consensus on strategies for “out-of-hospital” care. This is important because patients who are severely mentally ill require careful monitoring and complex management activities to prevent relapse. (Santos, 1997).

The shortage of mental health providers in rural areas is often compounded by the lack of less formalized, but not unimportant, sources of support. Often missing, for example, is consumer and family advocacy for mental health that is often present in urban settings (MH: Report of Surgeon General, 1999). Also missing in many rural settings are coordinated efforts such as Assertive Community Treatment (ACT) teams that rely on both numbers of patients and numerous local resources for their success. Clubhouses, drop-in centers, and other support services, also, are less often available in rural areas.

Inequities in access to mental health services in rural and frontier populations are well documented. The lack of mental health and health care services in those areas points again to the need for parity in mental health funding. Parity for provider reimbursement

that accounts for potential practice costs differences may help reduce supply shortage. Parity in mental health benefits in consumer cost-sharing will reduce financial burdens on those who do seek mental health services. Comprehensive mental health parity can go a long way in reducing inequities experienced by rural and frontier residents and meet their needs for mental health services.

Recommendation 11. Parity in coverage between mental health services and physical health services should be pursued in Federal and state law and regulation.

Fragmented public funding

Medicare and Medicaid - Medicare and Medicaid are both important safety nets. Persons covered by these two public programs are over 6 times more likely to have access to specialty care than the uninsured are (McAlpine & Mecahnic 2000). Medicaid, in particular, has been of critical importance for many persons with serious and persistent mental illness. While more than 800 rural counties have high poverty rates, only 25 percent of people living in rural areas qualify for Medicaid, compared to 43 percent in urban areas (NIMH, 2002). Enhancement of eligibility and coverage in Medicaid in many states could potentially improve access to mental health services for rural residents. Medicaid payments, however, are often too low to attract a broad array of providers who are capable of providing optimal psychiatric care and treatment.

Medicare pays for outpatient, inpatient and partial hospitalizations for treatment of mental illnesses. Coverage for mental health services is quite similar to coverage for physical illnesses. However, the Part B coinsurance rate is much higher (50%) for mental health professional services than for physical health services (20%). Although the National Plan for the Chronically Mentally Ill of 1980 recommended changing the 50 percent coinsurance to 20 percent for physician mental health services (Koyanagi & Goldman, 1991), the 50 percent coinsurance rate remains in effect today. For rural residents in poverty stricken areas, such a high coinsurance rate makes paying for mental health services nearly impossible. Given that consumers are more sensitive to prices for mental health services than for physical health services (Manning et al., 1987), the likelihood of them seeking mental health services is significantly reduced.

In addition to Medicare and Medicaid, the Federal government funds special programs for adults with serious mental illness and children with serious emotional disability. These Federal programs include the Community Mental Health Block Grant, Community Support programs, the PATH program for people with mental illness who are homeless, the Knowledge Development and Application Program, and the Comprehensive Community Mental Health Services for Children and Their Families Program. (U. S. Department of Health and Human Services, 1999)

The 1996 Welfare Reform has introduced significant changes in the Supplemental Security Insurance (SSI) Program. Though little evidence is available on the impact of the reform on rural SSI beneficiaries' access to mental health services, tracking of SSI

caseload shows that about 100,000 adult substance abusers and about 100,000 disabled children were cut from the SSI rolls. Some case study evidence also suggests areas of concern, especially for disabled children, in whether they will have access to health insurance coverage and appropriate care and whether the loss of SSI income will make families of disabled children more vulnerable to economic shocks or other crises (RAND, 2001).

State and local government - State and local governments have been the major payers for public mental health services historically and remain so today. The States have dramatically reformed their mental health systems began in the community mental health era of the 1960's and 70's. State reforms became more focused in the 1980's following development of the Community Support Program (CSP) approach. CSP promoted a new understanding of serious mental illnesses as long term disorders requiring ongoing but flexible community-based treatment and support services. This era also saw a return of mental health leadership to the States and better Federal financial support for reform. Significantly, the increased Federal support was not primarily through dedicated mental health programs, but through changes that made Social Security and Medicaid supports more accessible and relevant to people with mental illness. This approach facilitated change, but made the task of managing State systems more complex because of the need to integrate many unrelated Federal and State funding streams. (Lutterman & Hogan, 2001). The table below illustrates the sources of public funding for eligible mental health services, an array of services and funding sources which consumers may have difficulty understanding.

Table. Public Funding for Eligible Mental Health Services Applicable to Non-Metropolitan Residents

Public Programs	Funding Source	Eligible Services
Medicaid	Federal and state	Psychiatric rehabilitation, psychosocial rehabilitation, mental health clinics, psychiatric care of nursing home residents, limited medications. Medicaid home and community-based services waiver provisions in section 1915(c) of the Social Security Act pay for assertive community treatment, prevocational, educational, and supported employment services, and expanded habilitation services for mentally retarded ("Federal," 2000).
Medicare	Federal	Original Medicare: Outpatient, inpatient, and partial hospitalization mental health care. Part B providers include doctors, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, and physicians' assistants, limited medications.

Table. Public Funding Programs (continued)

Public Programs	Funding Source	Eligible Services
Community Support Program	Federal and state	Community-based treatment and support services, including appropriate housing, rehabilitation, and traditional treatments
Community Mental Health Block Grant	Federal	Children mental health Plan, covering screening and emergency service for children's psychiatric intervention, and psychiatric community residence program for 5-10 or 11-17 years olds (New Jersey Department of Human Services [NJDHS], 2002a). Adult mental health plan covers acute care programs and crisis stabilization, intermediate care and rehabilitation, and extended/ongoing support programs (NJDHS, 2002b).
PATH program	Federal	Service for the mentally ill homeless, covering alcohol or drug treatment services, outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, supportive and supervisory services in residential settings, referrals for primary health care, job training, educational services and relevant housing services, coordination of housing services. No medications (Substance Abuse and Mental Health Services Administration [SAMHSA], 2002a).
Comprehensive Community Mental Health Services for Children and Their Families Program	Federal	Diagnosis and evaluation, outpatient, emergency, intensive home-based and day- treatment services, transitional and case management services, and respite care (SAMHSA, 2002b).
Indian Health Services	Federal	Culturally relevant care for persons and families experiencing emotional distress. Outpatients & Inpatient services, Prevention programs for federally recognized American Indians (Indian Health Services, 2002).
Supplemental Security Income	Federal	Pre-release program for persons being discharged from state institutions, allowing them to qualify for SSI so that they can be eligible for Medicaid, even after cash assistance is reduced to zero.

Table. Public Funding Programs (continued)

Public Programs	Funding Source	Eligible Services
Social Security Disability Insurance	Federal	Disability payments (cash and Medicare benefit 24 months after the first SSDI check) for persons with qualified disabilities according to the medical listing
Community Mental Health Centers	Federal	Outpatient, inpatient, consultation and education, partial hospitalization, and emergency/crisis intervention, no medications but may do medication check (SAMHSA, 2002c).
Department of Juvenile Justice, Medicaid	State	Multisystemic Treatment

Fundamental as funding for mental health services is for the well-being of rural persons with mental illnesses, income support or health insurance programs fell short in meeting the needs of the rural mentally ill as is well documented in the literature. Perhaps it is because the task of navigating the complex and perplexing array of funding mechanisms for specific services that may be eligible for either state or federal funding is simply too daunting. The funding level may not be sufficient to compensate providers to practice in rural areas. While the cost of living is lower in rural areas, the costs of practice and residing in rural areas may be quite high especially if we factor into social, educational and recreational needs. There are also very few opportunities for achieving economies of scale to reduce administrative costs for rural practitioners. Policies targeting simplification of funding mechanisms and adequately accounting for costs of practice may improve providers' willingness to practice in rural areas and therefore enhance access.

Unemployment rates are high among people with severe mental illness, yet surveys show that most want to work (Crowther, Marshall, Bond, & Huxley, 2001). The passage of the ADA and the Rehabilitation Amendments of 1992 has motivated some states to provide vocational rehabilitation services for their severely mental ill residents. The New Hampshire community mental health centers have implemented effective vocational rehabilitation programs that are rated satisfactory by consumers (Young, 2001). Vermont's mental health system implemented a supported employment program for over two thousand severely mentally ill patients that was strongly correlated with competitive employment outcomes at ten community mental health centers in the state. Higher competitive employment rates were strongly correlated with overall program fidelity and with two program components, namely, providing services in the community as opposed to providing them in the clinic and using full-time employment specialists as opposed to staff with mixed roles (Becker, Smith, Tanzman, Drake, & Tremblay, 2001). Another supported employment program modeled after the assertive community treatment program also has shown an average employment of 33 percent, compared with the employment rate of 5 to 21 percent reported for persons with severe and persistent

mental illnesses (Becker, Meisler, Stormer, & Brondino, 1999). Multiple randomized controlled trials find that supported employment is more effective than pre-vocational Training in helping severely mentally ill people to obtain competitive employment (Crowther et al., 2001)

> **<u>Recommendation 12.</u> Support is needed for service integration efforts for both children and adults that can identify sources of program support and eligibility for the range of necessary services for mentally ill persons.**

Managed behavioral health and Medicaid managed behavioral health

Most private insurance policies cover only 50 percent of mental health outpatient visits, compared to 85 to 90 percent for all other illnesses. The number of outpatient visits allowed for mental health treatment is often restricted each year. The presence of managed behavioral health is positively associated with urbanization. While community-level measures of behavioral health carve-out penetration are not available, the effect of managed care penetration on access to mental health care was assessed using data on the penetration of HMOs across counties using national household survey data. HMO penetration rates were found to affect access to behavioral health care only through their effect on access to general medical care. Access to behavioral health care in high HMO penetration areas leads low HMO penetration areas by 24 percent (Gresenz, Stockdale, & Wells, 2000). As most rural areas have low HMO penetration rates, it can be inferred that access to behavioral health care in rural areas is low.

Private health insurance has been transformed by managed care in the last decade. Coverage for mental health services can be either carved-out of traditional health insurance plan to managed behavioral health plans or carved-in within the traditional plan. Effects of carve-outs in general have been encouraging in terms of increasing benefit generosity, reducing inpatient mental health services use, and increasing the use of outpatient mental health services (Ma & McGuire, 1998; Grazier, Eselius, Hu, Shore, & G'Sell, 1999; Sturm, 1999). Very little evidence is available regarding the experience of the rural mentally ill with carve-out plans. Doubts have been expressed about the ability of MBHOs to improve access to mental health services for rural residents. Evidence suggests that they have fallen short of the mark in a number of states (DHHS, 2001).

The behavior of rural providers presents additional challenges in consideration of such funding arrangements. Some analysts consider that as long as rural primary care providers are able to negotiate contracts with health plans that do not involve risk sharing, the impact of carve-outs on access for rural residents is likely to be neutral (Rost et al., 2002). If rural primary care physicians are paid according to a fee schedule, they have a financial incentive to treat common mental health disorders like depression and anxiety. However, care provided by these physicians is often given without assigning a mental health diagnosis in order to minimize the negative impact of stigma and higher out-of-pocket costs (Rost et al., 1994a). Such deliberate miscoding can be problematic in light of professional ethics and also causes inaccurate documentation of prevalence and

treatment rates for mental disorders. It misrepresents the risk profile of covered members and misleads rate setting calculations. While some may argue that this practice at least gets patients some care, it is unclear if appropriate care is provided because it is difficult to perform quality assurance and quality improvement for mental health services if the diagnoses are deliberately undocumented or incorrectly assigned.

In contrast, if primary care physicians share risk through capitated payments or withholds, they have a financial incentive to refer patients to the behavioral health company. Referring patients with mild to moderate severity to the specialty sector will not be beneficial if mental health specialists are substantially less available, accessible and acceptable to rural residents. For many primary care physicians, unless their patients pay out-of-pocket, they would not treat mental illnesses. Therefore, as mental health service use is historically much lower in rural areas, due to myriads of problems regarding perceived need, access, and treatment adherence, efforts to reign in utilization by managed care techniques could exacerbate the long-standing under-use problems (Lambert, et al. 1998).

Alternative payment sources must also be considered. Another barrier related to health insurance can be difficulties in purchasing affordable policies. Like other small business owners, farmers can have difficulties obtaining affordable private insurance premium rates. This difficulty in part explains the high rate of the uninsured in rural areas. Public funding is really the safety net for rural residents with mental illnesses. When public funding is insufficient, exploring alternative funding mechanisms, e.g., philanthropy may help support of expand the safety net in rural communities. While limited involvement of philanthropy in improving mental health is reported in a predominantly urban setting (Meehan, Kaufman, Carling, & Palmer, 2001), no evidence exists of involvement of philanthropy in rural areas. Improved communication with the philanthropy community regarding the needs of rural communities may be required. As the philanthropy community aim to help the most vulnerable and disenfranchised members of the society, the needs of the rural mentally ill are no less than their urban counterparts.

The dominant form of managed behavioral health plans in rural areas is Medicaid managed care plans. More than half (57%) of state Medicaid mental health and substance abuse carve-out programs are publicly managed (Pires, Stroul, Roebuck, Friedman et al., 1996). As Medicare and Medicaid are the most common types of public insurance for persons who are severely mentally ill (SMI), and they significantly increase the likelihood of receiving specialty care. Policies to improve care for SMIs, therefore, should be considered in relation to these public programs.

Medicaid Managed Behavioral Healthcare Organizations (MMBHOs) that carve-out mental health benefits from other health benefits have been expected to produce benefits for rural areas. That is MMBHOs were to reduce costs, reduce use of inpatient mental health care, increase reliance on outpatient care, direct more patients to mental health specialty providers, to make mental health providers more available to rural areas, and to manage providers in rural areas (see, for example, Lambert et al., 2001, Mechanic,

2001). As a result, the kinds of cost-cutting measures used by managed care organizations, such as reduction of hospital days and encouragement of short-term outpatient therapies, have not worked as well in the public sector with seriously emotionally disturbed children as they have in the private sector (Stroul et al., 1998).

The impact of Medicaid managed care on mental health of beneficiaries has been documented by various studies. For example, a Medicaid behavioral carve-out for youth pilot program in North Carolina has shown significant reductions in use of inpatient care, with a shift to intensive outpatient services, and less growth in mental health costs (Burns, Teagle, Schwartz, Angold, & Holtzman, 1999). While a significant number of North Carolina residents live in rural areas, the effect on rural youth of this Medicaid carve-out pilot was not reported. There is a general lack of empirical evidence on the effect of Medicaid managed care on rural residents with a few exceptions.

An evaluation of five states' mandatory managed care and eligibility expansions examined experience of mentally ill SSI beneficiaries in one of the states, Tennessee. Findings show that the beneficiaries have experienced significant problems with care coordination, unmet needs, and low service use levels. The evaluators also conducted focus groups in all five states among mental health providers and found them overwhelmingly dissatisfied with the programs. (Brown, Wooldridge, Hoag, & Moreno, 2001).

An evaluation of mental health services in Utah's capitated Medicaid managed care carve-out program could not shed light on rural experience of rural beneficiaries because the three community mental health centers that entered capitation contract with the State's Medicaid program serve predominantly urban beneficiaries (Christianson et al., 1995). However, it can be inferred, from another evaluation of the outcomes for Medicaid beneficiaries with Schizophrenia under Utah's Medicaid mental health carve-out plan that rural residents with severe mental illnesses might have fared worse compared to what would have happened under traditional Medicaid. This study showed that Medicaid beneficiaries with schizophrenia improved less under carve-out program than under traditional fee-for-service Medicaid (Manning et al., 1999).

Although MMBHOs appear to shift more patients to outpatient care, their record on providing more specialty mental health providers to rural areas or managing providers in rural areas is quite mixed. Montana is a case of where lack of specialty providers in rural areas led to failure of an MMBHO directed at shifting patients to specialty providers (Lambert et al., 1998). There are numerous reports of the inability of MMBHOs to constrain the behaviors of the scarce rural providers because of the lack of alternative providers.

MMBHOs have faced even more challenges in serving the mental health needs of rural children. Inadequate coordination between state Medicaid programs and other child welfare, education, and juvenile justice organizations in planning MMBH programs is complicated by the fact that many Medicaid children suffer from serious emotional

disturbances for which outpatient care, the strength of MMBHOs, may be ill-suited (Stroul et al., 1998).

Based on a few state's MMBH experiences with children with serious emotional disturbances, rural areas do not have the needed services and funding is insufficient to provide for the needed support services, as in New Mexico; or expanded services to children may contribute to MMBH failure to adequately contain costs, as in North Carolina. Both of these states have recently terminated their MMBH programs (Lambert et al., 2001). These and terminations of MMBH programs in several other states point to challenges and uncertainties faced by state MMBHOs (Lambert et al., 2001).

NIMH is funding an evaluation of a project implemented by a managed care organization in Armstrong County, Pennsylvania. The project hired a psychiatric nurse who spends half of her time serving in a rural community mental health center and the other half time in the clinic as a pediatric nurse practitioner. With her special training, she can screen for ADHD and other chronic conditions and enhance referral to specialty mental health services. Preliminary data show the "double-duty" psychiatric nurse improves quality of care and has increased referral to specialty mental health services by 10-20 percent. The program is planned for expansion to other clinics (personal communication).

A recent recommendation has called for state Medicaid agencies to require contracting MBHOs to monitor the impacts of their policies on service effectiveness to rural beneficiaries (NRHA, 1999). A broader range of accountability issues and recommendations have been offered recently by state agency leaders (Bazelon Center for Mental Health Law, 2000). These recommendations and existing monitoring policies require additional support in addressing rural mental health. The formal mental health infrastructure in much of rural and, especially, frontier areas of America can only be described as thin and extremely fragile. For these reasons, managed behavioral health care plans across the states and state mental health plans should contain provisions monitoring the status of mental health provision in rural areas and requiring forecasting of the likely impact of existing or newly proposed arrangements on mental health provisions in rural areas.

Recommendation 13. Managed behavioral healthcare organizations wishing to contract for providing services to rural residents should show actual capacity for providing care to rural areas and should be held accountable through rigorous accountability assessments.

Disease Management

Managed care companies, pharmaceutical firms, and provider organizations are pursuing disease management strategies with regard to mental illness, especially depression. Such programs have often been found to be successful in improving treatment outcomes. Also, depression management programs in comparison to usual care can improve antidepressant treatment, depression severity, and perceived health status

among high utilizers of medical care (Katzelnick et al. 2000). In addition to reducing mental illness, the coordination of mental health services with primary health care has frequently been found to contribute to reductions in medical care costs (Mumford et al., 1998).

There is growing recognition that effective treatment of both physical illness and mental illness benefits from care coordination (e.g., disease management, case management, community-oriented primary care and numerous community initiatives in mental health treatment). Care coordination is being promoted in many physical disease categories by Medicaid programs, recent Medicare coordinated care studies, BPHC, and commercial health plans. An emphasis on care coordination in treatment in mental illness emphasizing physical and mental illness co-morbidities, primary care and mental health professional linkages, assertive community treatment programs, and other models – should receive additional attention in government administered and MBHO delivered mental health services, especially in rural areas where there are not near enough mental health professionals to meet local needs.

The Geisinger Health Plan, associated with the large, rural, multi-specialty group practice-based Geisinger Health System, employs depression screening across all of its health plan patients who are participants in any of seven disease management programs. A positive response to one or two questions in a two-question protocol is followed by administration of a mood survey to determine if the patient should be referred to a primary care physician for further diagnosis and treatment (Sidorov, personal communication, March, 2002).

An academic medical center and pediatric group practice partnership in Pittsburgh employs a waiting room, touch-screen-based depression and substance abuse screening program for postpartum mothers. This serves as the basis for a referral to further care in a mental health specialty unit in an academic medical center.

Private and public payor contracts with MBHOs and/or care providers should consider disease management approaches that include family members or other informal support person in patient education and medication compliance reporting.

> **<u>Recommendation 14.</u> Depression screening, depression management, and possibly other mental illness management approaches should be considered as part of a normal course of care for those receiving care funded by the federal government and state governments.**

Promoting sustainable development of evidence-based practices

Since its inception in the late 1960s, Assertive Community Treatment programs have developed into a nationwide and international program for the severely mentally ill (“Assertive,” 2002). At the initiation of the Texas Department of Mental Health and Mental Retardation, a consensus building meeting on assertive community treatment standards was held in 1996. Recognizing assertive community treatment as the most

effective service delivery model for community treatment of severe mental illness, the National Alliance for the Mentally Ill (NAMI) focused on assertive community treatment development as a major initiative of its Campaign to End Discrimination (Santos, 1997). NAMI was successful in making assertive community treatment a service eligible for Medicaid reimbursement. In 1996, 14 state mental health authorities made assertive community treatment programs a core strategy in their state mental health plans (Santos, 1997).

In assertive community treatment programs, clinicians provide continuous care in non-institutional settings. Services are rendered flexibly in the client's community surroundings on an on-going basis as opposed to the traditional illness relapse episode-oriented strategy of inpatient care ("Assertive," 2002). As a "hospital without walls," it allows for the application of pharmacologic treatment within a well-structured and field-based community support system; the generalist team of providers is continuously available to monitor and support mentally disabled adults living independently in their communities (Santo et al 1995). In comparison to usual treatment, assertive community treatment programs not only reduce inpatient psychiatric service use, but also improve clients' ability to live a meaningful community life outside of mental health institutions, whether partial or full hospitalization (J. Meisler, personal communication, March, 2002). Among many studies, one randomized clinical trial shows that assertive community treatment participants were about 40 percent less likely to be hospitalized during the follow-up period. The effect was stronger for older patients. Lower assertive community treatment client/staff ratios also reduced the risk of hospitalization. No evidence of differential race effects was found. Previous results on assertive community treatment can be applied to non-emergency patients even when the control condition is an up-to-date Community Mental Health Center office-based case management program (Salkever et al., 1999).

The assertive community treatment models have been well accepted by clients and family members (Stein & Test, 1980). There also are some preliminary results suggesting that employing peer (i.e., consumer) or family outreach workers on the multidisciplinary assertive community treatment teams increases positive outcomes (Dixon, Hackman, & Lehman, 1997; Dixon et al., 1998) and creates more positive attitudes among team members toward people with mental illnesses.

A pilot study developed an assertive community treatment program for patients in rural South Carolina and evaluated the effect of the program on rates of hospital utilization and cost of care (Santos et al., 1993a). Although the methods of assertive community treatment may need to be modified to suit the travel requirements and other characteristics of rural settings, the study results suggest that the model can be successfully used in rural areas in reducing inpatient service use and costs (Santos et al., 1993a). A larger demonstration project was funded by the NIMH which permitted expansion of the assertive community treatment model in rural areas by testing its effectiveness with a randomized trial. The results of the demonstration are not yet available.

As a model of family preservation practices, home-based multisystemic therapy serves as an alternative to hospitalization for youths in psychiatric crisis (Schoenwald & Henggleler, 1997). The emphasis of multisystemic treatment is on providing a family- and community-based alternative for youths at imminent risk of out-of-home placement in facilities such as inpatient psychiatric units, juvenile detention centers and residential treatment centers (Henggeler et al., 1999). The focus of support is on building the strengths of the families, friends, schools and communities surrounding these youths. It has been shown to be effective in improving psycho-social functioning for youths with serious problems relating to substance abuse, serious emotional disturbances and violence. Its clinical and cost effectiveness as a family- and community-based mental health and substance abuse service has been documented (Henggeler, 2002).

Multisystemic treatment intervenes in a wide variety of systems – family, peers, school, and community – to manage problems identified in youths' natural ecologies (Santos et al., 1995). Under the program, a staff member trained in multisystemic treatment is on call for each child, 24 hours a day and also spends several hours a week with a family for four months. At the beginning, the family and the staff member identify the family's strengths and weaknesses and set goals together. During treatment, the staff members help the family learn how to communicate and manage conflicts. Parents also learn how to discipline and reward their children more effectively, become involved in their school performance, and develop a positive community support network.. There are about 5,000 children receive multisystemic treatment services each year. A 1998 study by the Washington State Institute for Public Policy estimated that graduates of multisystemic treatment committed 44 percent fewer felonies than juvenile offenders who did not participate in the program. Multisystemic treatment costs about $5,500 per client, while imprisonment or residential treatment costs about $30,000. The cost savings go even further: Because far fewer multisystemic treatment clients commit crimes after treatment, society saves an additional $40,000 for each youth in the program, the study said (Family Service Center 2002).

The applicability of multisystemic treatment to rural youth are being evaluated by several studies. A multi-site randomized clinical trial designed to replicate multisystemic treatment to urban and rural youth is currently funded by the National Institute for Mental Health and underway (Scheonwald 2002). Another NIMH-funded study is evaluating the extension of multisystemic therapy of violent juvenile offenders to two rural sites (Scherer, Brondino, Henggeler, Melton, & Hanley, 1994).

Reform in financing for mental health services is imperative to sustainable implementation of clinically proven evidence-based innovative treatment programs such as Assertive Community Treatment, and Multisystemic Treatment for rural residents and their children. Provider organizations often have little incentive to develop and deliver more cost-effective community-based patient-focused services as long as restrictive services such as psychiatric hospitalization continue to be relatively better compensated and the compensation for community-based services are either poor or are more difficult to obtain. If they have to navigate multiple federal and state agencies (e.g., Medicaid and the juvenile justice system for multisystemic treatment, rehabilitation and Medicaid for

assertive community treatment) in order to get community-based services covered, while inpatient services can readily be paid for by Medicaid, the providers have the incentive to use the latter. Funding implications are addressed in subsequent recommendations.

Broad dissemination of program innovations such as assertive community treatment, multisystemic therapy, and supported employment cannot occur without the support of the state agencies responsible for the care of the populations targeted by these interventions (Santos et al., 1995). Salient aspects of these successful programs could bring new insight to how to better design services that produce positive patient outcome instead of provider-driven crisis-oriented traditional services. For example, ongoing monitoring of team members and continued training and booster training sessions are held regularly with weekly on-site supervision of a doctoral-level mental health professional with expertise in providing family-based services. In addition, rewards are provided for positive client outcome and flexibility exercised when providing care that meets the clients' needs, rather than merely for following guidelines (Santos et al., 1995).

These promising practices need to gain legitimacy and be seen as viable and credible programs rather than mere experiments or expendable add-ons. There are strong indications that these community-based, culturally-rooted programs, with 24-hour wraparound service availability, result in substantial cost savings by preventing more costly, out-of-home services. To that end, the services must be evaluated effectively. (Center for Effective Collaboration and Practice**,** 2002b) Barriers to broader implementation of assertive community treatment program include inflexible reimbursement policies of third party payers, resistance by mental health professionals, and uncertainty about whether the approach is suitable for communities that are culturally different from the setting in which it was developed (Santos et al., 1993b). Payment sources for multisystemic treatment programs are not yet a standard part of Medicaid program in most states. The opportunity to reallocate state funds comes from cost-savings generated by these community-based services when they reduce costly and recurring inpatient care for the severely mentally ill or Juvenile correctional services incurred by emotional disturbed youth. While the multisystemic treatment program in the State of South Carolina earned Medicaid payment for home-based youth services to that reflect the central clinical thrusts of multisystemic treatment (Santo et al 1995), other multisystemic treatment programs are paid for by Juvenile Justice Departments or research funds. Integrating them into established funding mechanisms will ensure sustainable development and benefit a larger population of youth, therefore prevent youth violence and preserve families.

Funding agencies will enjoy good return on their investment in developing innovative practices if the practices are sustainable and are replicated successfully in other areas. Medicaid expenditures can be reduced significantly in areas where assertive community treatment and multisystemic treatment are successfully implemented. The reduction in long term or recurring inpatient psychiatric services use or incarceration in correctional facilities can all translate into savings and better lives for the severely mentally ill or emotionally disturbed youth. A large number of pilot programs have been funded with both public and private funds. Many of them show potential promise in

improving access and acceptability of mental health services to rural residents, e.g., the multisystemic treatment, the assertive community treatment, and various approaches among Native Americans ("Center**,**" 2002a)**.** The interface between these practices and Medicaid reimbursement and various other sources of public funding (e.g., juvenal justice systems, Division of Mental Health, Division of Vocational Rehabilitation, etc) must be considered by policy makers to achieve sustainability and to benefit a larger community of patients with mental illnesses.

> **<u>Recommendation 15.</u> Care coordination for mental health conditions (e.g., disease management, case management, assertive community treatment programs, multisystemic treatment, and numerous community initiatives in mental health treatment) should become integral parts of Medicaid, Medicare, and other government administered and privately insured, fee-for service, and MBHO delivered mental health services, especially in rural areas where there are not near enough mental health professionals to meet local needs.**

Support for other promising practices.

Community-based health organizations or providers might take on responsibility for coordinating a range of services in support of the mental health needs of particular rural population groups, e.g., the elderly (like the Program for All inclusive Care for the Elderly-PACE) or youth (like county or regional youth service systems). Similarly, rural health organizations, e.g., rural FQHCs and critical access hospitals (CAHs), in underserved rural areas are being charged with taking on greater roles in mental health services. The CAHs, too, are encouraged to develop rural health networks supporting coordination among local organization and linkages to those in more populous areas. The cost-based reimbursement standards under which these two types of organizations function may provide greater stability for mental health services in the areas they serve.

> **<u>Recommendation 16.</u> Critical Access Hospitals (CAHs), FQHCs, and other primary care clinics should receive attention as possible coordination hubs for rural mental health services, especially in light of shortages of specialized mental health professionals and reliance on primary care physicians.**

Conclusions

It is inviting to search for one-best solution to address the mental health needs of rural Americans. There are some systemic issues such as a need for a more equitable supply of mental health specialists and parity in insurance for the mentally ill. At the same time, there are differences in the social composition and mental health access problems of rural areas across the country that may call for unique solutions from one state to another or even across regions within the same state. States also differ in the extent to which they have in place particular public and private provider organizations to meet mental health needs. MBHOs have been promoted as a "solution" to some mental health access and/or cost problems. There is some evidence that MBHO can work in areas that offer sufficient provider resources, but that they are not necessarily able to overcome severe limitations in availability of providers to meet the needs of severely mentally ill populations.

Creativity is needed in linking MBHO and/or other public and private initiatives that promote strong linkages among primary care and mental health specialists and strong relationships between patients, care professionals, and supportive care networks representing family, friends, employers, schools, and other service agencies (child and/or aging services) depending upon the patient being served.

Especially in the face of budget threats, it is critically important that providers of mental health services, medical care, education, and social services work in a coordinated fashion to effectively address mental health needs. The application of disease management technologies in depression and other mental illnesses offer hope of both addressing mental health needs and improving effectiveness of medical treatment for other conditions. Effective treatment of mental illness improves opportunities for children attending school, employees remaining engaged in productive work, and troubled child or depressed or confused adult staying out of more costly jails, nursing homes, or partially institutionalized setting.

Evidence-based interventions such as assertive community and multisystemic model demonstrate how multiple community resources can be concentrated to effectively care for the mentally ill. These techniques may require the support of state agencies, including authorizing the participation of their local agencies in such efforts, which may ultimately reduce total service demands and costs for participating agencies. At the same time, FQHCs and Critical Access Hospitals may become critically important players supporting some form of mental health services for people in many otherwise underserved rural areas. These facilities, both in services they offer directly and their ability to network with other providers and agencies may be critically important to meeting the needs of the rural uninsured and other rural patients.

Finally, rural America must continue to rely on a mix of strategies—variously involving public, nonprofit, and private sectors—to meet a growing mental health needs. It is doubtful that many rural areas can attract mental health specialists by relying simply

on market forces or workforce mobility patterns. These forces, in fact, seem to work counter to the interests of rural mental health access. Training and recruiting rural people for mental health professional roles, incentives for professionals to enter and remain in rural practice, and encouragement of collaborative strategies among the available providers and organizations to maximize the impact of limited mental health dollars must remain high priorities in policy and action.

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