

MENTAL HEALTH OUTREACH:
Promising Practices in Rural Areas

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National Association for Rural Mental Health

November, 2001

For

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

INTRODUCTION

In many rural areas there is a chronic gap between the need for and availability of mental health services. Even where services are available cultural issues and stigma may impede rural persons from receiving the mental health care they need. The importance of **outreach services** connecting rural persons to appropriate mental health care has long been recognized. However, the many challenges of delivering mental health care in rural areas often relegate outreach services to a secondary status, particularly given the lack of on-going funding for outreach.

Despite these obstacles, many rural programs and agencies have come up with creative approaches for performing outreach, often in response to specific community needs. Several important events and trends also have heightened interest in how to better reach and serve rural persons needing mental health care: the Farm Crises of the 1980s and 1990s; natural disasters including floods, fires, and hurricanes; school violence; and growing immigrant populations in previously non-culturally diverse areas. A number of outreach programs have been developed to meet the needs manifested by these events. These programs often are made possible by the availability of targeted funding to address specific categorical needs.

There is a large gap between the increased interest and activity in rural mental health outreach and knowledge about it. To address this gap, The Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA) contracted with the National Association for Rural Mental Health (NARMH) to review and present successful approaches to rural mental health outreach. The project that resulted had three goals:

- ◆ Find out how rural mental health outreach is currently being done;
- ◆ Determine promising models and approaches; and
- ◆ Produce a product that helps those wanting to develop rural mental health outreach.

A work group comprised of several members of the NARMH Board of Directors and a consumer surveyed the field (this effort is described in the section on methods). We found that rural mental outreach is currently being conducted in a variety of service settings and communities. While these outreach programs vary in terms of staffing, specific services, and populations served, there are some compelling similarities among them and these similarities form the basis of our recommendations for doing rural mental health outreach. Our most important finding is that **successful outreach programs address the needs of consumers – as they perceive and identify them – in the context of the communities in which they live.** Thus, it is not just a matter of where outreach services are delivered, but what issues they address and how. Outreach services must work within the context of their communities. Because “one size doesn’t fit all” and relatively little evaluation of outreach services has been done, we call our recommendations “promising” rather than “best “ practices.

This paper is presented in six sections. Following the introduction, the background section describes the history of efforts to promote and provide rural mental health outreach. The methods section describes how we surveyed current rural mental health outreach programs, followed by a section describing the major types of programs we found. The next and major section of the paper presents promising practices for developing (So, You Want To Do Outreach), implementing (Doing Outreach), and maintaining (Keeping Outreach Going) outreach based on the experience of the programs we surveyed. The last section presents recommendations directed at policymakers to help support and enhance rural mental health outreach.

We hope that this paper will be the beginning, rather than the end of the conversation, about how to do rural mental health outreach. We include in our Appendix a list and brief description of rural outreach programs graciously responding to our survey. We invite readers to discuss the findings and recommendations of this project, on-line at the NARMH Web-site: www.narmh.org.

BACKGROUND

The need and challenge of reaching out to rural persons to connect them with mental health services are long standing problems. Following the Community Mental Health Centers Act (1963), federal funding facilitated development of satellite clinics in remote areas (Geller et al. 1997). These clinics were connected to larger community mental health centers and staffed by mental health professionals, often on a part-time basis. These clinics tend to be costly given relatively high overhead and low volume. There has been a steady decline in the number of satellite clinics since the shift from categorical to block-grant funding in 1981 for community mental health centers and with the growth of managed care over the last decade (Geller et al.1997).

Linking or integrating rural primary care and mental health providers has been a long-standing policy goal backed intermittently by Federal initiatives and funding over the last thirty years (Bird et al. 1998; Lambert et al. 1996). While primary care – mental health integration remains a cornerstone of rural service delivery, its efficacy as a means of outreach remains limited. Integration usually takes root where there is a tradition or culture of cooperation between primary care and mental health providers and is difficult to foster when these factors are not present. The heavy caseloads of both rural primary care and mental health providers often impede coordination, even when there is a desire to do so.

Individuals located in, or travelling through, the community also have also been vehicles for reaching out to isolated rural persons needing mental health care. “Circuit riders” have been used to help persons living in very rural (usually frontier) areas get mental health help (Geller et al. 1997). These riders might be a judge, preacher, teacher, or mental health professional who would be travelling through rural areas for other purposes. Their work is often connected to community agencies, including schools and churches. Additionally, there is a long history of using lay community health workers (also called indigenous para-professionals) to provide community mental health care (Hollister et al. 1985; Wagenfeld et al. 1994).

These approaches -- while useful -- are limited by the availability of sustained funding. The Rural Crisis Recovery Act contained in the Farm Bill of 1987 helped support direct funding of rural mental health services (including outreach), as does the Rural Health Outreach Program of the Federal Office of Rural Health Policy. These funding sources have been instrumental in establishing new rural outreach programs and services, but still leave programs facing the question of how to sustain outreach services once initial grant funding ends.

Outreach has generally been viewed as ancillary or external to core mental health services. There is an important change occurring in how many policymakers and providers view the nature of community-based mental health services. The Community Mental Health Act of 1963 mandated the development of community-based services to treat persons newly removed from state institutions as well as to provide mental health services more broadly to other populations. The brick and mortar of state institutions had been transferred to the community: one goes to a community mental health center and sees a mental health professional in his or her office. While this conception has remained powerful for over thirty years, different models and practices of community mental health are emerging, which recognize the benefit of serving consumers in the venues in which they live and may feel most comfortable. This helps to empower consumers, increases access, and often results in more effective treatment.

To frame and proceed with this project, several key issues needed to be addressed. The first issue is **what is outreach?** Outreach can be defined more narrowly or broadly and can be thought of as including or being ancillary to traditional core mental health services. The second issue is what information about the **organizational context** in which outreach services are delivered needs to be known to understand how outreach is done and what may constitute promising practices. Too little information and outreach services will appear to be abstracted and it will be difficult to know where promising practices may be adapted. Too much information and one will get bogged down in it and outreach services may appear to be limited to its current organizational home. The third issue is what aspects of the **cultural context** of outreach services need to be known. Cultural sensitivity and competency are considered crucial to reaching out to specific populations groups that may be

defined in terms of ethnicity, age, and occupation. It is important to know whether and how outreach workers are recruited and trained to be “culturally competent” to the persons they may serve and whether outreach programs make other cultural accommodations to the persons to whom they reach out.

METHOD

The National Association for Rural Mental Health (NARMH) recruited a working group to conduct this project. NARMH Board members recruited included a regional director of mental health in Massachusetts, an executive director of a community mental health center in Vermont, the executive director of the Farm Resource Center -- an outreach program serving rural communities in four states -- and an academically based rural mental health services researcher. A mental health consumer -- who has served as mental health agency program director and is currently the editor of Vermont’s consumer newspaper -- was recruited to the work group.

To learn how rural mental health outreach is being done, the work group reviewed the literature, spent an evening meeting with four rural outreach workers from the Farm Resource Center, and developed and conducted surveys of rural mental health outreach programs. The work group first reviewed the published literature on rural mental health outreach, which is scant and relatively dated. The work group realized that to identify promising practices it would need to get information from workers and programs currently doing outreach in rural areas. The work group spent an evening meeting with four rural outreach workers from the Farm Resource Center (two from Pennsylvania and two from West Virginia). A list of questions was distributed to the outreach workers including how the workers were recruited, trained, what aspects of their job were the most important and which were the most challenging. The workers were quite forthcoming about the challenges and rewards of their jobs. They all emphasized that an outreach worker must understand his or her community and the people they are serving.

The meeting with the outreach workers provided a good basis toward understanding the basic challenges of providing rural mental health outreach, but the group recognized it needed to know more. The group decided to identify and survey current rural outreach programs. Approximately 200 rural programs were identified from the Year 2000 list of the Federal Office of Rural Health Policy outreach grantees (indicating they delivered mental health services) and from NARMH’s membership lists. Programs were mailed a one page survey that asked the recipient (1) whether their agency currently has outreach services, (2) to describe these services briefly, and (3) what they would do to enhance outreach if more resources were available. The cover letter explained the purpose of the survey and provided a working definition of outreach: “providing services to persons not receiving appropriate mental care, including persons receiving no care and persons not receiving as much care as they need.”

Forty surveys were returned because of an incorrect address. Forty-one of the remaining 160 surveys were completed and returned. In several cases, two or more surveys referred to the same larger organization and were discounted. Five agencies reported that they currently did not do outreach. In the end, twenty-eight agencies / organizations (from seventeen states) currently doing rural outreach completed the initial survey. The intent of the survey was to solicit information from current programs and was not intended to be a representative sample. Thus, we were very pleased with this return and with the completeness of the information provided.

The Work Group met to review the results of the survey. The review revealed that outreach was being conducted across a variety of settings and to different population groups. A follow-up survey (Appendix 2) was designed and included specific questions about challenges to providing services, inter-agency affiliations, how outreach workers are used/recruited/trained; how persons come to access and use services; cultural issues and accommodations; and recommendations (the “two most important things”) for developing an outreach program. Twenty-four of the twenty-eight agencies responded to our second survey and the Work Group reconvened to review this more detailed information, which is described in the next section. This information provides the foundation for our discussion and recommendations.

Limitations: Because of resources, this project is not based on a comprehensive survey of all rural outreach projects. In particular, smaller more discrete efforts of outreach, not involving specific agencies or organizations, are not likely to have been picked up in our search.

TYPES OF OUTREACH PROGRAMS

The programs that we surveyed provide an important snapshot of rural mental health outreach today. This snapshot revealed that programs tended to vary by whether outreach was general or very specific ("tailored") and to which population it was directed. We grouped these programs into four categories so that we could compare them to better understand the organizational context in which they operated:

- ◆ Tailored outreach to specific populations
- ◆ General outreach to specific population
- ◆ General outreach to mental health populations
- ◆ General outreach to general populations.

Tailored outreach to traumatized populations involves culturally specific outreach to persons experiencing stress and loss due to trauma introduced by economic failure and, or, natural disasters. This is exemplified by two outreach programs developed to serve farmers, their families, and their communities in the wake of the economic trauma introduced by the farm crises of the 1980s and the recent downturn in the farm economy: (1) The Farm Resource Center (FRC) and (2) Sharing Help Awareness United Network (SHAUN).

The *Farm Resource Center* was established in Illinois in the mid-1980s with initial funding from the Rural Crisis Recovery Act contained in the Farm Bill of 1987. THE FRC has since expanded its services into other states and is currently assisting rural farming communities in Pennsylvania, West Virginia, and North Carolina (as well as in Illinois). Key elements of the FRC model that have evolved over time are that services are:

- ◆ Not driven by diagnostic codes,
- ◆ Provided without cost to the consumer,
- ◆ Assessable through a confidential toll free number, and
- ◆ Provided by culturally sensitive workers trained to know and respect their limitations.

The FRC recruits and trains workers from the areas it serves. It is not attached to larger service programs and relies on specific earmarked funding from state, federal, or philanthropic sources to pay for the services delivered.

The Disaster Mental Health Relief Programs, run by SAMHSA, have adapted FRC's model. FRC has also produced an Outreach Manual, funded by and available through SAMHSA. The "no-strings attached" funding available to FRC when a disaster strikes, or with successful advocacy, also has a serious down side. The organization needs to be almost constantly fund raising and it is always competing against other budget requests.

Founded in 1999, *SHAUN* provides peer support and professional mental health assistance to Iowa farmers and their families who are dealing with an agriculturally related death, serious disability, and related mental health issue. SHAUN grew out of the larger Sowing the Seeds of Hope Project (including seven mid-western states) run by The Wisconsin Office of Rural Health and Wisconsin Primary Care Association and supported by funding from the Federal Office of Rural Health Policy. With "patched together" funding, SHAUN began services in April 2000. Similar to the FRC, Shaun recruits outreach workers from the communities it serves and offers comparable training.

General outreach to a specific population involves a single program that targets a specific group. The *Healthy Connections* Program in Mena, Arkansas targets at-risk families with a probability of child maltreatment. This program operates in one of the state's most rural and poorest counties. All social services are located in the county seat, in the northern region of the county.

Without outreach services, some families would need to travel 100 miles round-trip to receive care. The *Hazard Perry County Community Ministries* program in Eastern Kentucky serves adults with serious mental illness within a large mountainous service area. The outreach worker's challenge is to find the people living in the "hollow" between the mountains and to get their basic medical and social (food, shelter) needs met. The outreach worker is the crucial link between the consumer and the homeless shelter, psychiatric hospital, and outpatient mental health services. The *ElderLynk* Program serves rural elderly persons in an eight county area in Northeast Missouri. Outreach staff (credentialed in their own areas) locate, or are contacted by families or persons themselves, and then link them with appropriate services. The *North Coast Senior Services* program in Oregon targets persons age 60 and older who are mildly to moderately depressed. As with the *ElderLynk* program, advertising and community education are key functions and the outreach workers attempt to link persons with needed services. This program operates under a broader senior services agency serving two counties.

General outreach to mental health populations include community mental health centers providing outreach to some or all the populations they serve. *Southeast Mental Health Services* in La Juanta, Colorado provides community support services to adults and elderly persons with serious mental illness in six counties (including frontier and rural) in southeast Colorado. *Aroostook Mental Health Services* serves a very large catchment area in northern Maine. Outreach is considered a core mental health service and is targeted at adults with serious mental illness, children, persons with substance abuse problems, elderly persons in group homes and nursing homes, and persons in emergency or crisis situations. Between fifty to seventy-five percent of persons in these groups are treated through outreach.

Ferry County Community Services in Republic, Washington provides outreach to persons of all ages and with varied mental health and substance abuse needs in a very rural mountainous county, 100 miles long and 70 miles wide. Outreach workers link persons to other mental health, general health, and support services. Because of the relative isolation of the area and many of its citizens, the program is careful to try to understand its populations and their needs and to "leave some folks alone who want to be isolated."

General outreach to general populations include community health centers providing mental health services to persons in their catchment area. The *Butte Community Health Center* in Butte, Montana attempts to identify and link persons to appropriate mental health services throughout its service area. This area is located at the top of the Continental Divide, has nine months of winter and the highest unemployment rate in the country. This relatively new program is funded by a Federal rural outreach grant and primarily coordinates its services with the Western Montana Mental Health Center. The *University of New Mexico, Department of Psychiatry* provides training and offers consultation on behavioral health to rural primary care centers in selected areas in New Mexico. Psychiatrists from the Medical school provide annual continuing educational sessions and also work with nurses in rural primary care clinics around issues of assessment and diagnosis and medication management. The *Rural Mental Health Consortium* in Bismark, North Dakota, also funded by a Federal rural health outreach grant, serves eight rural communities in six counties. On average, each community is 80 miles from Bismark. The program attempts to work closely with health and human services agencies to provide basic mental health services in these distant and very rural areas (five persons per square mile).

Providing an international perspective is The *Headlink South Rural Psychiatric Team* in Christchurch, New Zealand that targets adults with severe mental illness. Almost all efforts at coordination are with primary care practitioners or practices, which are more dispersed than mental health services in the large catchment area. A Maori outreach worker travels to tribal meetings to help establish a link with indigenous populations.

How programs view outreach

Programs were asked what they considered outreach to be. Overwhelmingly, programs indicated that outreach was an activity or service that extended beyond the walls of the mental health center (or other agency) and promoted the availability of mental health services. Programs varied in what specific "outreach services" they offered and their short-term goals for outreach tended to reflect the particular population groups they were targeting (e.g., children, adults with

severe mental illness, older persons). The short-term goals sometimes reflected the particular challenges of the geographic area to be served. However, what is most striking about these responses is that there is much more emphasis on the challenge of and need for engaging consumers in their "choice of location" than in having to overcome long distances, terrain, or weather. Engaging consumers in locations where they are comfortable is seen as empowering and ultimately resulting in better outcomes.

PROMISING PRACTICES

So, You Want To Do Outreach

If you work at a mental health or primary care agency in a rural area, chances are there are persons in your service area not receiving the mental health care they need. Some are not receiving any care and others are not receiving as much care as they need. These persons may not be getting this care because they live far away from available services, they feel too ashamed to be treated for a mental health problem, or they don't have insurance or financial resources to pay for it. Others may not even recognize that they have a problem or that their problem can be helped.

Starting or enhancing outreach may be an important step to help these persons receive the care they need. Before deciding whether and how to do outreach, you need to consider carefully several important questions. What are your specific reasons, or goals, for wanting to do outreach, what populations do you intend to serve and what services will you provide? What type of outreach workers do you need, how do you recruit and train them? Where will you get the money to support outreach? With whom in the community will you need to work?

Decide what your goals are

What are the major problems you want to address? Be specific about your goals. Being specific about your goals will help you decide other important issues such as what type of outreach workers and which community partners you will need. Your need and goals are likely to drive your effort to get money to support outreach. Your goals are likely to address specific populations and groups. It is useful for your goals to address what you want to accomplish in reaching out to these populations.

The Healthy Connections Program in Mena, Arkansas serves one of the state's most rural and poorest counties and targets at-risk families with a high probability of child maltreatment. These families generally involve very young, unwed mothers and/ or single mothers with multiple children. The program's specific goals are to "reduce the rate of child maltreatment; reduce frequency of second / subsequent pregnancies; improve parenting skills; and reduce corporal punishment." Healthy Connections focus on at-risk families has led them to be a coalition partner with several governmental agencies, social service agencies, educational facilities, and Arkansas Advocates for Children and Families.

The Northwestern Mental Health Center in Crookston, Minnesota targets outreach services to adults with serious and persistent mental illness and children with serious emotional disturbances. Their primary goal is to improve skills and resiliency and their secondary goal is symptom management. These goals are reflected in the outreach services they provide -- child and family assessment, skills building to parents, social skills for children, and crisis intervention.

Recruiting and training outreach workers

At the heart of successful outreach is having the right people to do it. Outreach workers must understand the people they are trying to reach - their circumstances, their needs, their community. Outreach workers must be willing and able to meet and work with consumers on their own terms and where they live. The consumer must trust the outreach worker. These are not easy tasks, given rural reticence and the stigma associated with mental illness.

The Farm Resource Center and SHAUN suggest that the kitchen table is the ideal place - and the proving ground - for doing outreach. Can you sit around the table and be accepted by the farmer and his or her family? Do you have the understanding that while clinically the farmer is (or may

appear to be) depressed, his or her reality is the overdue payments that keep him up at night, or fear that she is letting down the generations before her that worked this land?

Sometimes, there is a preliminary test the outreach worker must pass before he or she even gets to the kitchen table.

"Although workers must be very professional in the performance of their jobs, they should be able to tolerate walking out to the barn or shop as part of the 'get acquainted' ritual during which the farmer evaluates his or her readiness to deal with personal emotional issues."

Roger Hannan, Executive Director, Farm Resource Center, "How to Reach Farmers With Mental Health Services", NARMH Party-Line, Winter 1999

There are other important attributes an outreach worker should have. He or she should be a self-starter and manage their time well. At the same time, the outreach worker must be flexible and understanding of the time and other constraints faced by the consumers they are trying to reach. An assessment is not likely to be finished in a fifty-minute session. The assessment may take two or three sessions, with some last minute cancellations thrown in. An outreach worker must understand his clinical limits and that his role is to engage and assess the consumer and refer him or her for help if that is needed. As described below, an outreach worker must connect with the local community and gain their trust as well.

All the qualities a good outreach worker must have are a pretty tall order. How do programs train outreach workers? In part this depends on what type of agency is doing outreach. Community mental health centers tend to employ a mix of professional and paraprofessional staff to do outreach. Professional staff have a practice credential and receive a relatively intense, short training in outreach. The presence of continuing education in outreach is usually not required. Paraprofessionals also receive a relatively intense, short training in outreach and are more likely to receive continuing education than professionals. Volunteers tend not to be used very much by community mental health centers. Primary health care agencies tend to use a mix of professional and paraprofessional staff and provide a modest amount of training to both. The Farm Resource Center relies on paraprofessionals to find and engage consumers and to link them with professional mental health providers. The Farm Resource Center trains paraprofessionals more intensely than most community mental health centers.

There is considerable variation in the scope and formality of training of outreach workers in the programs responding to our survey. In general, there is a sense that it would be better if more training could be provided, but this is difficult because of financial and logistical factors (availability of trainers, ability to get outreach workers to trainings).

“ We have an elaborate training curriculum including an initial 90 day training program for new hires, weekly training every Friday on video so other offices can participate. We have classes that teach diagnosis and doing paper work correctly. We have classes on medication management and on the psychosocial model of case management, that emphasizes consumer empowerment.”

Southeast Mental Health Services, La Juanta, Colorado

“There is a very specific training program for case management aides. Regular training programs are conducted either by staff, outside professionals or sometimes by some-one from the pharmaceutical industry. We also have teleconferences provided by the Office of Mental Health. Employees sometimes travel to conferences.”

Lewis County Community Mental Health Center, Lowville, New York

“We use primarily a paraprofessional model, employing consumers and caregivers. The initial training includes three weeks of didactic training in mental health, substance abuse, health communications, HIV, hepatitis, listening skills, and home visiting. All staff go through state DMH/DMR Case Management Level I Certificate Training.”

Hazard Perry County Community Ministries, Hazard, Kentucky.

“We do a lot of in-service trainings ourselves and cover areas that we feel are relevant. We also provide a stipend for staff to go outside for training each year.”

Range Mental Health Center, Virginia, Minnesota

“Staff training is not well organized. We deliver it through in-services and conferences.”

-- Community Mental Health Center

So, it is very important to recruit the “right type” of outreach worker, described above, and to monitor and support them when they start doing outreach. Outreach workers are most often recruited from the communities (or from similar communities) that they will serve. Professional (credentialed) outreach staff have had previous education and training. Paraprofessional staff are usually recruited from the occupational or cultural group that they will serve. Denominational and lay ministers often make very effective outreach workers because they understand their community and can relate to community members on their own terms. Retired teachers and government workers often have the knowledge of local communities to become effective outreach workers. Consumers can share their experiences and own sense of recovery and be very effective volunteer, paraprofessional, or professional outreach workers.

An outreach worker should:

- ◆ Believe in the philosophy and goals of outreach
- ◆ Understand the people they are trying to reach – their circumstances, their needs, their community;

- ◆ Be able to meet and work with persons on their own terms and where they live;
- ◆ Be flexible, a self-starter, and manage time well; and
- ◆ Understand their role and limitations.

It is also important to recognize when an outreach worker is “not working out.” This may be a professionally trained case manager who cannot make the transition from office-based practice to going out in the community. Or, a paraprofessional may not understand his or her role and the need to work closely with professionals

Finding the money

Outreach services can be started with demonstration grant money, special legislative authorizations, or incorporated into ongoing service delivery and supported through an agency’s general reimbursement revenues. Getting a demonstration grant or special authorization is great for getting started but leaves open the question of what you will do when the demonstration or special authorization ends. One strategy is to use the demonstration period to develop and hone your outreach services so that you can make a compelling case - either to your own agency and/or external funders -- to support outreach through reimbursement to your agency's general services. Sometimes funding can be leveraged or shared from other sources Partnerships with other community agencies with shared needs (e.g., serving children, older persons) may provide a basis in the future for sharing some financial support for outreach.

Get the money where you can to start and remember to keep looking for it.

Both The Farm Resource Center (FRC) and Sharing Help Awareness United Network (SHAUN) received designated funded to start serving farm families in areas undergoing economic hardship and are engaged in continual fund raising. The *Farm Resource Center* was established in Illinois in the mid-1980s with initial funding from the Rural Crisis Recovery Act contained in the Farm Bill of 1987. and has and is currently assisting rural farming communities in Pennsylvania, West Virginia, and North Carolina (as well as in Illinois). The FRC is totally dependent on legislative (federal and state), foundation and philanthropic support from the states it serves. SHAUN began serving farm families in Iowa in April 2000 with “patched together” funding. To survive, SHAUN will require a parent organization to support it until it can secure more stable funding.

The most common support for starting or enhancing outreach services are Rural Outreach Grants from the Federal Office of Rural Health Policy. The Rural Mental Health Consortium in Bismark, North Dakota serves eight communities in six counties through a rural outreach grant. On average, each community is 80 miles from the central office. The grant supports a licensed clinical social worker and a certified nurse specialist who visit nursing homes, schools, and primary care settings in these communities. The grant is also supporting the training of two additional certified nurse specialists.

The most stable foundation for delivering outreach is ongoing reimbursement for delivered services. The Mid-Columbia Center for Independent Living in The Dalles, Oregon focuses its outreach efforts on individuals vulnerable to abuse, neglect, or harm to self or others and provides most of these services through its case managers. Under Oregon's Medicaid managed care plan, there is flexibility to have these services reimbursed under the program's capitation rate. Aroostook Mental Health Services in Caribou Maine provides outreach in a variety of ways through long-term well-established programs, primarily involving case managers. This allows the program to support outreach through its regular sources of reimbursement (mental health, Medicaid). The Cumberland Mountain Community Services Program in Cedar Bluff, Virginia serves a very mountainous area in Appalachia and uses its entire staff – professional and para-professional to do outreach. Virginia’s Medicaid rules allowing for billing by paraprofessionals who have been trained.

It is easier for a well-established, strong community mental health center such as the Center for Independent Living, Aroostook Mental Health, and Cumberland Mountain Community Services to

integrate outreach services -- and consequently reimbursement for it -- into the way it delivers all services than for newer or more constrained agencies. There is a chicken and egg issue here -- these three community mental health centers are very successful and strong, in part, because they have been able to mainstream delivery of (and consequently reimbursement for) outreach services.

Working with community partners

Community partners are essential for outreach. They can be informal --- churches, Lion's club, sportsman's club, chamber of commerce -- or formal -- schools, primary health providers, other mental health providers, and social service agencies. Let people know what you want to do and how you might work together. This accomplishes several things:

- ◆ the community will welcome you, rather than freeze you out;
- ◆ other mental health agencies will not think you are there to steal their clients;
- ◆ you will be given tips on how to approach and engage consumers; and
- ◆ you will receive referrals from the community.

" Mental health centers wishing to connect with the farming community should work at developing a relationship with the Farm Bureau, Cooperative Extension, and other farm groups. Credibility is the name of the game in reaching farmers. Farm groups can open or close their community to service providers. Another tip to gaining credibility is to recruit volunteers, not for direct service but to help spread the word about the service."

Roger Hannan, Executive Director, Farm Resource Center, "How to Reach Farmers With Mental Health Services", NARMH Party-Line, Winter 1999

"Networking can solve problems before they start."

Healthy Connections, Mena, Arkansas.

"Turf issues take time to resolve and trust to develop."

Hazard Perry County Community Ministries, Hazard, Kentucky.

"Ensure a network of relationships sanctioned by all partners so workers are delivering services under an approved umbrella."

Northwestern Mental Health Center, Crookston, Minnesota.

Doing Outreach

Finding and engaging people

At the heart of doing outreach is the ability to find and engage people needing mental health care. This is what outreach workers do and the other pieces of putting together an outreach program lead to this. To find and engage people, successful outreach programs address the needs of consumers -- as they perceive and identify them -- in the context of the communities in which they live.

" Go to where people are physically and geographically. Go to where people are psychologically and emotionally."

Aroostook Mental Health services, Caribou, Maine

"Deliver services at or near the consumer's choice of location -- ideally, at their kitchen table. This fully empowers the consumer in all decision making."

Farm Resource Center, Mound City, Illinois

“Understand the types of people you serve and their needs. This information should dictate their services.”

Ferry County Community Services, Republic Washington

“The Farm Wrap Program in Northwestern Minnesota attempts to connect with the farmer ‘where he or she is at’ through a process of helping that facilitates access to a full array of helping services for the farmer, beginning wherever the farmer is comfortable beginning. If the immediate crisis relates to a deadline on a loan repayment ...the outreach worker focuses on the loan.”

Dan Wilson, Executive Director, Northwestern Mental Health Center, Crookston, Minnesota. “Putting the Farmer In Charge of His Own Recovery.” Rural Mental Health. Fall 2001. National Association for Rural Mental Health.

Outreach programs find out about people - and people find out about the programs - in a variety of ways, including formal referrals from agencies; advertising in the media, public service announcements; church bulletins, and word of mouth in “out-of-the way places.” Programs directed at specific age groups, such as children and older persons, rely on referrals from agencies working with these age groups, primary care providers, as well as from self (and family-based) referrals. Outreach programs need to publicize their services and inform these agencies and the community about what they do. Community education and networking to foster referrals are not one-time activities. It is much better to have regular, on-going contact with other agencies and to provide ongoing community education.

“We link up with agencies and providers that are already serving our communities to coordinate and enhance their services. We use brochures, an 800-phone number, newspaper postings, radio spots, health fairs, community service groups, ministerial groups, and mental health breakfasts to reach people.”

Elderlynk, Kirksville, Missouri

“Our director did over 100 public presentations last year to different agencies and other community group regarding my program. I interviewed over eighty referrals resulting from this effort and processed over fifty into my program.”

North Coast Senior Services, Wheeler Oregon (Directed at detecting and helping mid to moderate depression in older persons)

Outreach efforts directed at children and older persons often involve “detecting” mental health problems as well as engaging these persons. Outreach efforts directed at adults with severe mental illness need to focus less on detection (generally, their illnesses are known) and more on engagement. For the most part, these persons are not linked, or only loosely linked with traditional mental health services. Hazard Perry County Community Ministries in Hazard, Kentucky attempts to reach adults who live in the “hollow” between the mountains. The program works with four community partners, based on an interagency agreement: a homeless shelter, a psychiatric hospital, an outpatient mental health clinic, and a Center for Rural Health. The program also works closely with local housing, transportation, and home health service agencies. Referrals are accepted from these partners and agencies, however all clients are clinically screened against admission criteria. The Kennebec Valley Mental Health Center in Augusta, Maine focuses outreach on persons with chronic mental illness who avoid or are not linked with traditional services. The Center belongs to a number of provider groups and consortiums and speaks weekly with sister agencies on a formal

basis. These groups and agencies know to call the Center with referrals, as do other groups, including the police.

Programs located in very rural areas rely on individual as well as on more formal sources of referral and use a variety of approaches to find and engage people. Ferry County Community Services is located in Republic, Washington serves a county 100 miles long and seventy miles wide with mountainous terrain. The Program advertises regularly in newspapers and weeklies; runs Public Service Announcements on local cable television in Republic; advertises in the telephone book; and relies on “word of mouth”, as well as on referrals by professional community gatekeepers.

Dealing with access and distance

Most programs serve relatively large rural areas with significant challenges to travel. Most programs report access issues, including transportation, to be significant challenges, but not insurmountable problems. These programs largely operate in rural areas, where most staff and consumers they serve, have grown up. Travelling long distances, or coping with difficult terrain or weather is the everyday reality. This does not make things easy, but it doesn't necessarily make them difficult. Some programs have been able to fund support for transportation through Medicaid.

What advice would you give to others starting a rural outreach program?

“Transportation and transportation. You can have all kinds of effective services but if people don't have a way to get to the services then you have to go to them...We absolutely have to provide transportation to our clients otherwise they could not access our services. We have 50 vehicles which we can support because we are approved as a Medicaid transportation provider.”

Cumberland Mountain Community Services, Cedar Bluff, Virginia

“Outreach workers go to consumers' homes to provide services. Support groups are within an hour's drive of consumers in that region. An hour is about as long as persons will drive to shop. The program does pay for services if there is a financial need and sometimes pays for transportation as well.”

Sharing Help Awareness United Network (SHAUN), Harlan, Iowa

“Isolation is an issue. However, the program owns eight vehicles used to provide outreach services. There is a need for five more vehicles.”

Northwestern Mental Health Center, Crookston, Minnesota

“We have invested a lot of money in transportation and have a full time driver. For people eligible for Medicaid, there is a system of Medicaid drivers who get reimbursed by the mile.”

Lewis County Community Mental Health Center, Lowville, New York

Accommodating cultural issues

Outreach programs must address the needs of consumers in the context of the communities in which they live. Cultural issues, often multi-layered, define much of this context. Privacy, self-determination, resiliency, and reluctance to acknowledge having a mental health problem, are values and characteristics common among rural persons. Rural outreach workers must understand and be able to work with, or accommodate, the cultural issues raised by these values and characteristics. Almost all the programs we surveyed are successful in hiring and training workers who do this.

Programs serving specific rural populations, including low-income families, older persons, or adults with severe mental illness living in the hollows of eastern Kentucky tailor their services to accommodate the culture and environment of the people they serve. Examples we have described include the willingness of meeting a farmer and his or her family on the farm and to interpret

farmer's insomnia and other "symptoms" in the context of his or her overdue loan repayment. Nearly all the programs we surveyed also make, or tried to make, this sort of accommodation.

More challenging to programs is when there are multiple cultural or racial/ethnic groups to serve. Several programs reported that they have one or two staff who are bi-lingual or bi-cultural. For some of these programs, additional staff of this kind would be helpful. Several programs reported growing rural Hispanic populations that will require staff to be more culturally competent than they are currently.

"Two persons in our agency are specialists on cultural issues. One is Native American, which is important because half the population of the county is Native American. There are also some black families; a few Latino families, some part -Asian residents, and some Viet Nam vets who have settled in the area. Whenever a minority person appears on the client list there is a consultation with one of the two specialists."

Ferry County Community Services, Republic Washington

"We have a very conservative religious community, including a Mennonite community. We have to be very sensitive to our religious population and sometimes have to contact clergy to reassure them that we are not a threat to their beliefs."

Lewis County Community Mental Health Center, Lowvile, New York

"Our program is specifically developed to address the agricultural community. Iowa farmers are primarily White. We will need to be able to address persons of different ethnic groups and nationalities in the future."

Sharing Help Awareness United Network (SHAUN), Harlan, Iowa

"Accommodating cultural issues represents a significant problem with a rapidly growing Hispanic population in our area and no planning by community leaders or caregivers on how to care for this population."

Healthy Connections, Mena, Arkansas

Deciding on how much you can do

It is exciting and satisfying to be able to reach persons who were not receiving the mental health care they need. These feelings are likely to be soon tempered by the realization that your program can't serve all the people who need your help.

"The need is still overwhelming. There is no way to pay for mental health services for the uninsured, unless the Feds and state kick-in funds... We need more case management, therapy, and prescription medications. We need more money and creative service ideas."

Butte Community Health Center, Butte, Montana. Recent recipient of rural outreach demonstration grant. Located at the top of the Continental Divide. The area has nine months of winter and the highest unemployment rate in the nation.

You will need to decide how many people your program can serve and how many and what type of services you can provide the people you serve. Don't forget about the people you can't serve and the services you can't provide at the present time, but don't get overwhelmed by it either. Remember your community partners and think what you may be able to do with them. Think of other ways of getting funds to do more. But, most of all don't stop doing what you can do by

worrying about what you can't. You want committed, productive staff - but don't push them toward unreasonable goals.

Keeping Outreach Going

Starting your outreach program was difficult, keeping it going may be just as difficult. Major challenges are continued funding, retaining and replacing staff and revisiting your goals.

Continuing the funding

Most outreach programs are started by demonstration outreach grants (typically for three years), others are funded by special legislative authorizations, and some programs have moved outreach services – and reimbursement of it – into core service delivery. As suggested earlier, it is important that programs get the money where they can to start and remember to keep looking for it.

As your program gains experience and enjoys success with outreach, you will have a stronger case for integrating outreach into the mainstream of service delivery and for having outreach reimbursed by Medicaid or mental health funds. If you have worked with other agencies and providers, they may be willing to help you make this case, or contribute to the support of outreach.

Tele-mental health may be used to supplement existing outreach services and perhaps substitute for others if funding cannot be supported at current levels. Low bandwidth technologies such as 1-800 HELP LINES are always helpful and the cost of running and operating them can usually be shared among different health and social service providers. It may also be possible for outreach programs to tap into wider bandwidth video-conferencing networks if they exist in the communities. Among the programs we surveyed, Southeast Mental Health Services (La Juamta, Colorado) and Cumberland Mountain Community Services (Cedar Bluff, Virginia) use both lower and wider bandwidth technologies. Funding to support rural tele-mental health is potentially available through tele-mental health demonstration grants and through Medicare reimbursement for tele-health services for rural residents living in designated shortage areas. In some states (e.g., Arizona, Colorado, New Mexico, Oregon, Washington) Medicaid Managed Behavioral Health Programs have used tele-mental health to serve rural beneficiaries who otherwise might not have access to mental healthcare.

While you can – and should – pursue these various strategies within your community and state, federal policymakers need to make changes at the national level, to make your efforts possible. The last section of this paper spells out recommendations to federal policymakers to make these changes.

The challenge of ongoing fundraising for outreach is illustrated by the experience of the Farm Resource Center (FRC) over the past year. The FRC was invited in by the United Methodist Church to serve rural farming areas that had been devastated by hurricanes and the weakening of the domestic tobacco industry. FRC outreach workers have taken great care to introduce themselves and their goals to workers from the traditional mental health system and to be clear that they want to refer persons to the mental health services they need. The North Carolina Grange has fully endorsed the FRC's work in North Carolina and has actively lobbied the North Carolina legislature for funds to expand FRC's services statewide.

Retaining and replacing staff

Outreach is challenging, time-consuming work. There's a lot of travel, many of your clients may resist your efforts, and no two cases are likely to be the same. One would expect burn-out to be a significant problem. Contrary to what we expected, burn-out was not a major problem among the programs we surveyed. On the contrary, outreach workers tended to be among the most satisfied of all mental health workers. They believed in and saw the importance of what they were doing.

Nevertheless, recruitment and continuing education of outreach workers remain ongoing challenges. It takes a special person to be a good outreach worker. Continued education is important

so that an outreach worker can continue to hone his or her skills and to refresh himself. Having the opportunity to meet regularly with other outreach workers is important.

Recruitment of outreach workers is a significant problem. However, a service and repayment program that offers training for Certified Nurse Specialists has helped both recruitment and retention.

Rural Mental Health Consortium, Bismark, North Dakota

As paraprofessional (consumer) outreach workers gain experience they may be able to recruit and train other outreach workers. It is important for programs to continue to monitor the performance of outreach workers, as they would with other staff. If outreach grows within your agency and becomes more integrated with other services, are professional staff changing what they do, or doing their same old (office-based) job? If your caseload grows, can professional and paraprofessional staff keep up with it? Do you use, can you use, volunteers to help with outreach?

Revisiting your goals

When you developed your program, deciding what your goals are was one of the first things you did. It is important to revisit those goals. Are the target populations to whom you are reaching out, still the right ones? Can you do for them what you thought you could, e.g., “ find and engage them”, “teach life skills and resiliency”, “refer them to appropriate services”? Do you have enough outreach workers to do what you set out to do? Do you have the right kind of workers and do they have the right skills? What other populations should you serve?

How have your community partnerships worked out? Which partnerships can be improved and which need to be dropped? With whom might you also partner?

RECOMMENDATIONS TO POLICYMAKERS

There is a significant need for outreach mental health services in rural areas, but it is very difficult to initiate and sustain funding for these services. Most of the programs reviewed in this project have developed outreach services through external funding that is inherently precarious. These programs provide some very important lessons. If services are developed that address the needs of consumers in the context of their own communities:

- ◆ mental health services are likely to be more effective;
- ◆ mental health staff are likely to be more satisfied; and
- ◆ the goal of policymakers to keep persons out of institutions and out of crisis is more likely to be met.

Realizing these benefits requires that we view outreach in a comprehensive rather than in a limited context. In the main section of this paper we have provided advice to program level staff. In this last section, we present recommendations to policymakers that may help sustain outreach and move it from an ancillary to a core mental health service.

1. **Federal funding should take into account the costs of doing outreach.** Funding should be ongoing and mandated as a core service in state Medicaid plans and in funding of community mental health centers, free standing mental health service agencies, and in primary care agencies delivering mental health care. Funding should reflect the increased cost of conducting outreach in large sparsely populated areas, including long travel time and the need for transportation. Funding should help support the use of tele-mental health in rural areas, where needed and feasible. Timelines should be established for enacting these changes.

2. **Training curricula should be developed for delivery of outreach services in different rural areas, to different target groups, and for different mental health needs.** These curricula should be based on the experience and knowledge of peer outreach and involve consumers in the actual training. Federal funding should require and support training for delivering outreach mental health services.
3. **Federal and state funding support and curricula-based training should reflect the range of types of outreach workers needed in rural areas, including professional, para-professional, and volunteer.** Funding and training should be directed toward fostering coordination between these types of outreach workers and with other mental health, health, and social service providers and workers in rural areas.
4. **Research is needed - and should be funded and conducted - on the best ways to conduct mental health outreach in rural areas and on the impact of this outreach.** While we have identified promising practices in rural areas, there are several important areas that we need to know more about to improve rural outreach. Important questions include, what are the best ways: to engage rural persons in their homes; to solicit consumer-identified needs; and to frame and conduct meaningful outcome evaluation of outreach services to different groups in different venues.

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- Appendix One: Rural Mental Health Outreach Programs Responding to NARMH Outreach Survey.

Tailored Outreach to Specific Populations

Farm Resource Center

230B Main Street
PO Box 87
Mound City, Illinois 62963

The Farm Resource Center (FRC) was established in Illinois in the mid-1980s with initial funding from the Rural Crisis Recovery Act contained in the Farm Bill of 1987. The FRC has since expanded its services into other states and is currently assisting rural farming communities in Pennsylvania, West Virginia, and North Carolina (as well as in Illinois). Key elements of the FRC model that have evolved over time are that services are: not driven by diagnostic codes; provided without cost to the consumer; and provided by culturally sensitive workers trained to know and respect their limitations. The FRC recruits and trains workers from the areas it serves. It is not attached to larger service programs and relies on specific earmarked funding from state, federal, or philanthropic sources to pay for the services delivered.

Sharing Help Awareness United Network

1210 7th Street, Suite C
Harlan, Iowa 51537

Founded in 1999, Sharing Help Awareness United Network (SHAUN) provides peer support and professional mental health assistance to lowa farmers and their families who are dealing with an agriculturally related death, serious disability, and related mental health issue. SHAUN grew out of the larger Sowing the Seeds of Hope Project (including seven mid-western states) run by The Wisconsin Office of Rural Health and Wisconsin Primary Care Association and supported by funding from the Federal Office of Rural Health Policy. With “patched together” funding, SHAUN began services in April 2000.

General Outreach to Specific Population.

Healthy Connections, Inc

404 7th Street
Mena, Arkansas 71953-3203

Healthy Connections targets at-risk families with a probability of child maltreatment. The program operates in one of the state’s most rural and poorest counties. All social services are located in the county seat, in the northern region of the county. Without outreach services, some families would need to travel 100 miles round-trip to receive care. Three paraprofessional outreach workers serve fifty “at-risk” families with the goal of preventing child abuse and neglect.

Hazard Perry County Community Ministries

PO Box 1506
Hazard, Kentucky 41702

The Hazard Perry County Community Ministries program in Eastern Kentucky serves adults with serious mental illness within a large mountainous area. The challenge for outreach workers is to find the people living in the “hollow” between the mountains and to get their basic medical and social (food, shelter) needs met. The outreach worker is the crucial link between the consumer and the homeless shelter, psychiatric hospital, and outpatient mental health services.

Kennebec Valley Mental Health Center

66 Stone Street
Augusta, Maine 04330

The Kennebec Valley Mental Health Center serves two counties and uses two full-time equivalent outreach workers to serve persons with chronic mental illness who avoid or are uncomfortable with traditional community support or center-based services.

Outreach workers focus on engagement, meeting immediate needs, and linking with ongoing services when possible. The Center also participates in a multi-agency Crisis Outreach collaborative that serves persons in crisis (self defined or defined by others).

Youth Opportunities Upheld, Inc.

55 Lake Street
Gardiner, Massachusetts

Youth Alternatives serves children and adolescents who are the responsibility of the Department of Social Services, living in a one hundred square mile region that includes rural and inner-city areas. Seven professional staff work with the courts, schools, and other social service agencies to engage children in high intensity services, including after-school milieu programs and evening and weekend

activity based programs. Short-term goals are stabilization, family preservation, and reunification. The Massachusetts Department of Social Services funds the program.

Northwestern Mental Health Center

603 Bruce Street
Crookston, Minnesota 56716

The Northwestern Mental Health Center targets outreach services to adults with serious and persistent mental illness, children with serious emotional disturbances, and to farm families in crisis. The primary goal for outreach is to improve skills and resiliency and the secondary goal is symptom management. The program owns eight vehicles and serves a large geographic area, primarily with professional staff.

ElderLynk
800 West Jefferson
Kirsville, Missouri 63501

The ElderLynk Program serves rural elderly persons in an eight county area in Northeast Missouri. All eight counties are designated as mental health professional shortage areas. Five area health education and service providers have partnered with the ElderLynk to bridge the gap between existing services and barriers to elders receiving mental health services. Counseling services are placed within each county at Federally Qualified Health Centers & Rural Health Clinics with case management for follow-up and referrals. Outreach staff (credentialed in their own areas) locate, or are contacted by families or persons themselves, and then link them with appropriate services.

West Wendover City

PO Box 2530
Wendover, Nevada 89883

West Wendover is an outreach program, funded by a Federal rural health outreach grant, serving school-age children living in the Wendover region, which is a frontier area. Three quarters of the target population is Hispanic. Regular children's mental health services are one hundred and thirty miles from the Wendover area. The program is located within a local resources council that includes all the county's social service groups. Five part-time and one full time staff provide outreach to schools and provide mental health services there.

North Coast Senior Services

PO Box 87
Wheeler, Oregon 97147

The North Coast Senior Services program targets persons age sixty and older who are mildly to moderately depressed. One full time peer counselor (aided by a half-time assistant) advertises in and provides community education key functions and the outreach workers attempt to link persons with needed services. This program operates under a broader senior service agency serving two counties.

Cumberland Mountain Community Services

P.O. Box 810
Cedar Bluff, Virginia 24609

Cumberland Mountain Community Services serves adults with severe and persistent mental illness and children with serious emotional disturbances in a very mountainous area (Appalachia) in Southwest Virginia. This coal mining area has high unemployment, poor transportation, and is especially hard to travel in during winter. Over the last few years the Center has moved its focus toward serving persons in the community and treating people for long-term service needs. As a

result, the program has no formal outreach workers – “all staff do outreach.” Four Psycho-social rehabilitation programs provide outreach to consumers with Serious and persistent mental illness who “may be interested” in services. A Tele-N-Touch program calls isolated elderly individuals to check on their health and social contact.

General Outreach to Mental Health Populations

Southeast Mental Health Services

711 Barnes
La Juanta, Colorado 81050

Southeast Mental Health Services provides community support services to children, adults and elderly persons with serious mental illness in six counties (including frontier and rural) in southeast Colorado. The outreach team uses a professional model that includes two masters-level case-managers; an older adult clinician; four community case managers; a three-member emergency / crisis team; and one community support manager.

Aroostook Mental Health Services

PO Box 1018
Caribou, Maine 04736

Aroostook Mental Health Services serves a very large catchment area in northern Maine. Outreach is considered a core mental health service and is targeted at adults with serious mental illness, children with serious emotional disturbances, persons with substance abuse problems, elderly persons in group homes and nursing homes, and persons in emergency or crisis situations. Between fifty to seventy-five percent of persons in these groups are treated through outreach.

Range Mental Health Center

Box 1188
Virginia, Minnesota 55792

The Range Mental Health Center serves adults with severe and persistent mental illness in northern St. Louis County. This area, the size of Massachusetts, is wooded and comprised of many small communities. Seven staff persons, including professional and paraprofessional, serve over 600 identified individuals. Stigma in the rural community is a major barrier to persons being willing to receive mental health care. The program’s goals are to stabilize people and to keep them living in the community.

Lewis County Community Mental Health Center

7550 South State
Lowville, New York 13367

The Lewis County Community Mental Health Center serves adults with severe and persistent mental illness and children with serious emotional disturbances in a county of 27,000 people that primarily consists of dairy farms and woods and is very spread out. Transportation is a major barrier and the program has invested heavily to address it. The outreach team includes professional (intensive case managers) and paraprofessional (consumers) models.

Dutchess County Department of Mental Hygiene

230 North Road,
Poughkeepsie, New York 12601

This program targets adults with serious mental illness who are non-compliant and difficult to serve. Dutchess County (population 280,000) includes both urban and rural farm areas. A mobile mental health clinic serves the county and includes a psychiatrist; a psychologist, a social worker, a nurse, and a mental health counselor, and an expert on trauma. The mobile team provides up to six contacts in its attempt to engage and treat clients.

Rutland Mental Health Services

78 South Main Street
Rutland, Vermont 05701

This program provides mental health services to adults and children and their families in Rutland County, Vermont. Outreach services to children and their families are delivered through Head Start case management; school-based services, drug free school programs, therapeutic case management, intensive family based services, and short term home based services.

Ferry County Community Services

42 Klendike Road
Republic, Washington 99166

Ferry County Community Services in Republic, Washington provides outreach to persons of all ages and with varied mental health and substance abuse needs in a very rural mountainous county, one hundred miles long and seventy miles wide. Outreach workers link persons to other mental health, general health, and support services. Given the relative isolation of the area and many of its citizens, the program is careful to try to understand its populations and their needs.

General Outreach to General Populations

Clear Creek Community Service Center

1531 Colorado Boulevard
PO Box 3669
Idaho Springs, Colorado 80452

A multi-social service center in Clear Creek County serves two very rural mountainous counties in Colorado (Clear Creek and Jefferson) and is part of a larger (Jefferson County) mental health center. This Center is centrally located (in Idaho Springs) for both counties and offers “one stop shopping” that includes twelve major programs: human services assistance; nursing services; nursing service for early infants; mental health, substance abuse, voc rehab, work force; and developmental disabilities. While offering one-stop shopping, the center also views itself as a program without walls and reaches out to low-income persons throughout the two counties, including schools, jobs, and home.

Fulton County Health Department

700 East Oak Street
Canton, Illinois 61520

The Fulton County Health Department received a three- year Federal rural health outreach grant in 1998 to place four registered nurses in eight districts to provide mental health services to children and staff. The registered nurses also case manage difficult problems with children, provide education, consultation, and training in health related issues to school personnel, and make referrals to and coordinate with community agencies. A second aspect of the program is to hire a prevention specialist to organize the communities and put prevention programs in place. The program has been extended for a fourth year, using carry-over funds.

Butte Community Health Center

445 Centennial
Butte, Montana 59701

The Butte Community Health Center is a medical clinic that provides very limited case management and licensed therapy and attempts to identify and link persons to appropriate mental health services throughout its service area. This area is located at the top of the Continental Divide, has nine months of winter and the highest unemployment rate in the country. This relatively new program is funded by a Federal rural outreach grant and coordinates its services with the Western Montana Mental Health Center.

University of New Mexico, Department of Psychiatry

2400 Tucker, N.E.
Albuquerque, New Mexico 87131

The University of New Mexico, Department of Psychiatry provides training and offers consultation on behavioral health to rural primary care centers in selected rural areas in New Mexico. Psychiatrists from the Medical school work primarily with nurses in rural primary care clinics around issues of assessment and diagnosis and medication management.

Rural Mental Health Consortium

400 E. Broadway, Suite 300
Bismark, North Dakota 58501

The Rural Mental Health Consortium in Bismark, North Dakota, funded by a Federal rural health outreach grant, serves eight rural communities in six counties. On average, each community is eighty miles from Bismark. The program attempts to work closely with health and human service agencies – particularly nursing homes, schools, and primary care settings - to provide basic mental health services in these distant and very rural areas (five persons per square mile).

Mid-Columbia Center for Living

419 East Seventh Street
Room 207
The Dalles, Oregon

The Mid-Columbia Center for Independent Living in The Dalles, Oregon focuses its outreach efforts on individuals vulnerable to abuse, neglect, or harm to self or others and provides most of these services through its case managers. Outreach efforts involve providing services in community settings, including correctional facilities, schools, medical clinics, and nursing homes. The Center is actively involved in community partnering meetings and community events, including educational activities at local fairs and festivals. The Center conducts major outreach during mental health awareness month.

Healthlink South Rural Psychiatric Team

4th Floor, Healthcote Building
Cashmere Site
Christchurch, New Zealand

The Healthlink South Rural Psychiatric Team in Christchurch, New Zealand targets adults with severe mental illness in the Province of Canterbury. Almost all efforts at coordination are with primary care practitioners or practices, which are more dispersed than mental health services in the large catchment area (6,000 square miles). Core services include consultation, liaison, assessment and

treatment. Outreach clinics link with local small hospitals; home visits, and consumer support groups. A Maori outreach worker travels to tribal meetings to help establish a link with indigenous populations.

Appendix Two: Initial and Follow-Up Rural Mental Health Outreach Surveys

February 22, 2001

«First» «Last»
«Org»
«Add»
«City» «St» «Zip»

Dear «First»:

The purpose of this brief survey, is to discover how agencies in rural areas have been able to deliver outreach services to persons who were not receiving appropriate services. These services may include support, counseling, crisis and disaster intervention, access to other support networks, and case management. Outreach services may involve persons previously not identified as needing services, or persons requiring follow-up after more intensive care has been delivered. Sometimes, outreach services may be targeted to specific populations, including children; older persons; women; specific occupational or indigenous populations (e.g. families miners, minority populations, and people living in areas experiencing a natural disaster).

The National Association for Rural Mental Health's goal in conducting this survey is to identify elements or approaches in outreach models being used that can be applied elsewhere. We are also for looking for program approaches and service designs that can be adapted to serve specific populations more effectively in different types of rural settings. It is our intent to share these model programs and operational principles with mental health service providers and others who may wish to initiate or change delivery models in their communities.

NARMH is an organization of over 450 members that has worked for over 25 years to develop, support and link rural mental health services. This important project is made possible by a grant from Center for Mental Health Services/Substance Abuse and Mental Health Services Administration.

We recognize how busy you are. By taking a little time to complete the attached page, you will be helping others learn from your experience. By completing this survey, will:

- Have the opportunity to review and comment on our draft report..
- Be included in our final report.
- Receive a copy of the final report.

Kindly return this survey by **March 15, 2001**. If you have any questions about the survey, please contact me at (207) 767-6531, or DavidL@usm.maine.edu.

Sincerely,

David Lambert, Ph.D.
Rural Mental Health Outreach Project Coordinator

RURAL MENTAL HEALTH OUTREACH PROJECT

ORGANIZATION: _____

CONTACT: _____

ADDRESS: _____

PHONE: _____ E-MAIL _____

1. Do you currently have outreach service(s)? ___ YES ___ NO
2. IF YES, please briefly describe these services. Please include your geographic area, staffing levels, and target populations(s).
3. If more resources were available, what would you do to enhance current outreach activities? Describe specific areas of enhancement.

Kindly return this survey by March 15, 2001.
National Association for Rural Mental Health
3700 W Division Street, Suite 105
St. Cloud MN 56301
(320) 202-1820 Telephone
(320) 202-1833 Fax
narmh@facts.ksu.edu Email

FOLLOW UP QUESTIONS TO NARMH MENTAL HEALTH OUTREACH SURVEY (4/9/01)

INTRODUCTION:

Thank you for responding to the Rural Mental Health Outreach Survey sent to you by NARMH. We have a few follow-up questions that we would like to ask you. Is this a good time to answer these questions?

1. Please describe in a bit more detail, the population you are serving, with respect to:
 - target groups
 - population density
2. Please describe in a bit more detail the geographic area your program serves. Does this area pose specific, or unique, challenges and barriers to receiving care ?
3. How does your program interact (coordinate, receive formal/informal support, receive input) with other
 - Agencies?
 - services within your own agency?
 - community organization (eg business, clergy, schools)?
 - family, consumers and significant others?
 - purchasing/regulatory entities?

4. What types of outreach staff do you use and how are they recruited?

[Probe]

- professional model (credentialing for staff)
 - paraprofessional models (consumers, family, nonprofessional consumer members, other,
 - initial training requirements
 - volunteers (target peers, consumers, family, volunteers)
5. What types of ongoing training, services, support are provided to all staff?
6. What is your level of turnover and degree from burnout and how do you attend to it?
7. How many staff do you have?
8. How many clients do you serve?
9. What do you consider outreach? What are the specific types of outreach services delivered by your program?
10. What are the goals of the services [short term, long term] ?
11. How do people locate/find your program?
12. How does your program attend to accessibility issues including transportation?
13. How do you accommodate specific cultural issues?
14. If you were developing this program “from scratch” or giving advice, what are the two most important elements to keep in mind?
15. Has your program ever received an outside evaluation or gathered data to demonstrate the effectiveness of the data?