

# Development Process

This report is the result of an intensive effort by the National Association for Rural Mental Health (NARMH) to define a strategic direction for rural mental health in the year 2000 and beyond. The work began in May of 1997 with a focus group (see Appendix A) sponsored jointly by NARMH and the Center for Mental Health Services. The focus group explored policies, issues, strategies, solutions and recommendations regarding the provision of mental health services in rural areas. Ideas from the focus group were then presented in special sessions at a number of conferences where participants discussed the ideas and provided suggestions. Early drafts of the report were widely circulated for review and comment to rural mental health consumers, providers and policy makers. The report went through a number of revisions responding to comments and suggestions emerging during the review process. NARMH considers this report a living document that will evolve and grow as it guides rural mental health into the next century.

## Rural Mental Health: 2000 & Beyond

### Introduction

It has long been recognized that individuals in rural areas are more likely to be without a regular source of health care, without health insurance, in fair or poor health, and to be coping with a chronic or serious illness than individuals in urban areas (Norton and McMannus, 1989). Health and mental health resources have historically been concentrated in urban areas of the United States. Such locations contain over two-thirds of the population, but occupy less than ten percent of the land area. They tend to have a broad range and substantial volume of services. In contrast, rural and frontier areas traditionally have significantly fewer health and mental health resources available despite their sizable populations. In 1990, an estimated 56 million people lived in census defined rural areas.

Commenting on service scarcity, Human and Wasem (1991) reported that the limited availability, accessibility, and acceptability of rural mental health services creates serious consequences for individuals, families and state mental health authorities. The development of rural mental health services is restricted by the fact that few mental health professionals reside in these areas and by the relative inability of rural residents to pay for services. Rowland and Lyons (1989) in an article aptly titled "Triple Jeopardy: Rural, Poor and Uninsured" reported that 8.5 million rural individuals are uninsured and have incomes below 150% of the federal poverty level. Published reports of previous work groups have focused on the issues of access and availability, arguing that rural and frontier areas must be provided additional funding to ensure equity of resources (Beeson, 1994; Bergland, et. al., 1988; Kimmel, 1992; Larson, Beeson and Mohatt, 1993; Pion, Keller and McCombs, 1997; Wagenfeld, et. al., 1993).

Rural America has traditionally been viewed as a rather stable environment, somehow isolated from the many dramatic changes that occur in mainstream urban and suburban society. However, the farm crisis of the 1980's and the continuing economic decline of rural America in the 1990's have produced dramatic social and economic challenges (Ortega, Johnson, Beeson, and Craft, 1994). Many rural economies no longer depend on agriculture as the primary source of employment. There are an increasing number of rural jobs in manufacturing and services. Rural economic health is now affected by the same national trends, such as increased foreign competition, that affect urban areas (Meeks and Lawrence, 1988).

When reporting on the mental health of rural Americans during this period of turmoil, the National Mental Health Association (1988) concluded that:

... the 1980s have seen the beginning of a restructuring of rural America similar to the massive changes that followed the 1930 depression and those that occurred during the industrial revolution in this country. Great social and economic forces are drastically changing today's rural environment. In many ways this change represents a literal shrinking of population, businesses, services (schools, churches, health care, human services, mental health care, etc.), economic base, tax base and employment opportunities. (p. 13)

The "idealized myth" of life in rural and frontier America has long disregarded the substantial cultural and ethnic diversity, as well as the pervasive poverty, found in these areas. It is important that when planning for the future of rural mental health services, consumers, programs, agencies, states and the federal government cast off the "idealized myth" of rural life, and focus on the realities of modern rural existence. Concurrently, those receiving or delivering services within rural areas must move beyond their traditional "fair share" arguments - that they are not receiving the level of service they "deserve." Since funding allocations devoted to all social service programs are decreasing, an expansion of mental health services is, at best, a remote possibility in the vast majority of rural areas. Today, state and federal agencies are more functionally oriented and are not swayed by emotional arguments regarding service need.

## Thinking About Rural Mental Health

There is a reason one talks about **rural** mental health rather than mental health in rural America. It is because a focus on and a commitment to rural people and their problems has always been the priority and unifying force in rural mental health and the National Association for Rural Mental Health (NARMH). This belief that "rural" comes first has allowed the field to be relatively free of the turf battles and guild issues that have so fragmented the general field of mental health. Too often in the broader mental health arena, consumer needs have taken second place to the tiffs between academic disciplines and the various professions. NARMH and the field of rural mental health has as one of its primary strengths an emphasis on, and a sense of community in, service to rural people. This has allowed the profession to transcend differences and work together. Today there are more threats than ever before to this unifying force of rural mental health. These threats must be resisted the commitment to rural people and their needs must remain the primary focus.

Rural residents are rapidly losing political power and are becoming a disenfranchised minority. As Dyer (1997) recently reported, "Rural people feel powerless and disenfranchised because they are powerless and disenfranchised". Increasingly, people in positions of power and influence have no experience with or realistic knowledge about rural realities, resulting in either massive indifference or gross naiveté. Rural economies are struggling, and many rural areas face dwindling populations and eroding economic bases. In those rural areas where there is "growth," it often has an adverse effect on the local population and infrastructure. Growth due to mining tends to produce boom and bust cycles that wreak havoc on local economies and services. Growth due to industries such as meat packing often overwhelms local housing stock, schools and health services and changes the social and ethnic make up of communities. Growth that results from recreational development often drives up land values and taxes, resulting in the displacement of local populations. In these cases, the result is often a dramatic increase in mental health and substance abuse problems and a corresponding decrease in the political and economic influence of indigenous rural populations. The fact that "rural" is threatened also means that rural mental health is threatened. The disenfranchisement and powerlessness of rural people is also the disenfranchisement and powerlessness of rural mental health. The fate of rural mental health is intimately tied to the fate of rural America. Rural mental health professionals cannot be tourists in rural America. They cannot isolate themselves from the communities they serve and the people they provide services to. They must be good rural citizens and stewards of all that is good and valuable about rural life.

While people often talk and write about rural areas and populations as if they were a homogenous lot, it is important to remember that there are likely more differences within the category of rural than there is between the categories of urban and rural. Rural areas in the United States are remarkably diverse in both geographic character and the culture of indigenous populations. Delivering mental health and substance abuse services in the deep south is considerably different than responding to those same problems on the great plains. Differences in ethnicity heritage, population density and economic base make “one size fits all” solutions to rural mental health problems impossible. The types of disorders and the manner in which they are experienced, as well as their relative frequency, are likely to be different if the area’s primary economic base is farming, ranching, mining, lumber, tourism, or fishing. The treatment approaches that are effective in working with Black subcultures in the deep south are not likely to work with native American populations in the southwest. The service delivery issues facing providers in the relatively densely populated areas of the east are quite different from those facing the service providers in the remote and isolated frontier areas of the west. Finally, of paramount importance, consumer experience and needs vary, often dramatically from one rural setting to another. It is critically important public policy makers and program developers not seek a single rural mental health or substance abuse policy or program design.

While it is not always fully articulated or appreciated, the design and delivery of rural mental health services and substance abuse services requires a unique set of knowledge, skills, and abilities. Very few graduate programs train toward these competencies. Three enduring problems relate to the special set of expertise called rural mental health: (1) few people or organizations outside of the field of rural mental health recognize this area of expertise/competence; (2) the “field of rural mental health” has no mechanism to certify the people who possess these competencies, and (3) there are very limited opportunities (almost none for academic credit) for staff development and continuing education in rural mental health.

Rural mental health has a long history of being a public enterprise. It has been, and continues to be, dependent upon public funding and support. This, however, is changing. First and foremost, government at all levels is increasingly unwilling to subsidize either people or services. Second, there is increasing privatization of mental health services and funding. For example, government is turning over public programs such as Medicaid to managed care companies. Third, the development of health care networks is forcing rural mental health and substance abuse providers to “join up” or be left out in the cold. Many of the decisions that will affect rural mental health care delivery in the future will likely be made outside of government and outside of rural settings. All of this requires a more business-like stance on the part of rural mental health and substance abuse providers and professionals. Rural mental health providers must become fiscally tough and well-connected. They need to understand what it costs to deliver services and to achieve desired outcomes and how to be focused on being efficient as well as effective. Within the field there is an increasing need to build and maintain the relationships necessary for success. Linkages with others, especially primary care providers, are essential.

Substance abuse treatment and substance abuse professionals have always been an important part of rural mental health. NARMH has always counted substance abuse professionals among its members, published substance abuse articles in its journal, included substance abuse news in its newsletter, and incorporated substance abuse presentations at its national conference. Most rural mental health programs provide both mental health and substance abuse services under the same roof, and at times, through the same professionals. Still, it must be recognized that substance abuse issues in rural areas have not received the individualized attention they deserve. As the turn of the century nears, mental health and substance abuse are increasingly tied together under the rubric of “Behavioral Health”. In 1997 the National Council for Community Mental Healthcare changed its name to The National Council for Community Behavioral Healthcare. Most managed care firms that specialize in mental health and substance abuse refer to themselves as behavioral health organizations. The question remains whether this new bundling of mental health and substance abuse funding and administration has done anything to improve the integration of treatment at the point of service. Regardless of the label used to refer to these services it is clear that more needs to be done to bring these two bodies of knowledge together in a combined approach to meeting the needs of clients. Recent research has documented the futility of treating these problems in isolation from one another. More needs to be done to reach out and

provide effective treatment to persons with substance abuse disorders living in rural areas and to ensure that there is an integrated approach to meeting the needs of rural persons with co-occurring mental health and substance abuse disorders.

Approaching the century mark, it is easy to think that not much has changed. The themes of rural mental health remain constant: mounting needs and restricted/limited resources; unique geographic and cultural challenges to service delivery; lack of available professional staff; service providers struggling to operate under urban models and assumptions imposed by funding sources or regulators; consistent and pervasive misunderstanding of rural realities by state and national policy makers; the tendency to not take rural into account in public policy, or the tendency to want a single policy solution to rural issues; rural mental health advocates still struggling to be heard and more often than not left out of important policy discussions; and on and on. There is still debate about whether it truly costs more to deliver services in rural settings; whether rural populations are at greater, less, or equal risk for mental disorders; which models are best for meeting the mental health needs of rural residents; and whether new forms of payment for services (e.g., managed care) will harm or help.

A few bright spots shine through, however. Telehealth is making headway, providing important connections to rural and remote areas. The Internet is becoming a vehicle for greater connectivity among consumers, providers, and families. Some managed care ventures are using innovative approaches to increase access and availability. The recovery movement is providing a new paradigm for consumers, families, and professionals to work together toward a more hopeful and empowering goal. Unfortunately, not all rural mental health and substance abuse providers are taking full advantage of these opportunities.

Additionally, new trends in health care can potentially impact rural mental health. The changing structure of health care with the emergence of managed care and the for-profit health care corporation are changing the face of health care financing and delivery. The privatization of public health care insurance programs such as Medicaid and Medicare and the opening up of these resources to new management options has created more incentives for large corporate health care providers and insurers to enter rural markets. For example, the Budget Reconciliation Act of 1997 enacted changes in Medicare and Medicaid that will make rural markets considerably more attractive to HMOs and other managed care organizations. Rural hospitals and primary care providers are building networks and forming alliances with urban hospitals and health care corporations. Health maintenance organizations are entering rural markets. The private sector, especially, is treating mental health and substance abuse as an integrated set of behavioral health services.

There is, however, a continuing "Catch 22" about rural mental health. Providers constantly complain about costs and constraints but have not created the kinds of programs that are tailored to rural realities. Therefore, their costs do not truly reflect the real cost of delivering rural mental health and substance abuse services. Most rural mental health providers truly believe that it costs more to deliver mental health services in rural settings than in urban settings. However, the evidence suggests that it is, in fact, less expensive. This is due to the fact that while travel expenses are generally greater in rural areas, personnel and overhead expenses such as rent tend to be less expensive compared to urban areas.

A confounding factor relates to the issue of urban models. While most rural mental health providers complain about urban models being forced on rural settings, most rural mental health and substance abuse programs look very much like smaller versions of urban programs. In spite of the need to innovate and reach out to rural people, most rural mental health and substance abuse programs are smaller, under-resourced versions of their urban counterparts. They are office-based practices located in moderately-sized towns that see people on a one-to-one basis for 50 minute sessions. Though funding, regulatory mechanisms, and training programs contribute to this, rural mental health has done more complaining than innovating regarding models of service delivery. It may, in fact, cost more to deliver rural mental health and substance abuse services if those services are to be truly responsive and accessible to rural citizens. In summary, despite voicing complaints of being constrained by urban models and higher costs to reach clients, rural providers have developed few alternatives to urban models.

It is important for rural mental health consumers, practitioners, advocates, and administrators to clearly understand and articulate how the needs of rural citizens and the requirements of rural practice differ from

urban counterparts. Too often, differences are seen where there really are none, or one fails to notice subtle differences that may have a significant impact. In some cases, we made much ado about differences that are insignificant in their impact. This comes from failing to take a true comparative perspective. Providers typically do not compare experiences or data with those of their counterparts in urban settings. Assumptions are made regarding the uniqueness of experience or data and correspondingly about what it is like for urban counterparts. In doing this one runs the risk of basing program design, service delivery, and policy proposals on half-truths and myths. There is a clear need to promote a comparative perspective in rural mental health research and policy analysis to ensure discovery and understanding of the real differences between rural and urban settings and the real differences across the variety of rural settings and populations. Factors unique to rural settings, and knowledge of what is universal about the need for mental health services should be considered. More importantly, what are the true differences between rural and urban populations in their experience of mental disorder and their response to it? This knowledge can only be gained through research and analysis that looks at both rural and urban populations and settings within the same design and framework. Failure to gain this knowledge leaves us focusing on issues that are not unique to rural and places rural mental health care advocates unnecessarily at odds with their urban counterparts. Given the very limited resources available, there is a need to be strategic in focus by concentrating on what is uniquely rural.

Those in rural mental health continue to feel that if policy makers, funders, regulators, etc., were to truly understand, they would appropriate what is needed to meet the mental health needs of rural residents. Too often rural consumers and providers see themselves as victims and grumble to state and federal officials about being left out or unfairly treated. They look to be rescued from their plight, believing that with the right resources and appropriate public policy, it would be possible to meet all the mental health and substance abuse needs of rural residents. To some extent, this approach has worked leading to federal training, research, and technical assistance programs. There is appropriate recognition of some of the more problematic policy dilemmas. But for the most part, this has resulted in temporary infusions and spotty fixes to a set of enduring problems. Playing the victim role is both unhealthy and dissatisfying and is likely to be even less effective in the future. Rural mental health consumers and providers need to take the kind of advice being given to clients daily: "Take control of your life. Take positive action to improve your lot. Don't wait on the actions of others."

It is clear that more work needs to be done to take rural into account in mental health and substance abuse policy. There is a clear need for stronger advocacy for the special needs of rural citizens and the unique problems of rural mental health service delivery. Policy makers must be continually reminded that there is no one rural and no universal solution to rural mental health issues. For the enduring problems of availability, accessibility, acceptability, cost, continuity of care, and quality in rural mental health, adequate funding is only part of the solution. Yes, government at all levels should do more. Yes, universities and other training institutions should better prepare students for rural practice and focus research efforts on gaining better understanding of rural mental health issues. Yes, managed care firms need to recognize rural realities and develop flexible strategies to respond to rural mental health needs. Yes, advocates need to do more to ensure that decision makers in Washington and in state capitals across the country either through ignorance or prejudice do not create policies that harm rural mental health. Yes, there should be recognition that severe shortages of specialized mental health professionals in rural areas continue to be a barrier to meeting mental health needs. Yes, there must be better ways to provide technical assistance and to support continuing education for rural mental health practitioners.

The fact is there is a need to be strategic. This report could go on for many pages listing what consumers, families, providers, policy makers, administrators, educators, community leaders, and others could do to improve rural mental health. Such an attempt would in all likelihood end up on most people's bookshelves as a dust catcher. There is a need to find leverage points which have the potential to push rural mental health to the next level. This report proposes that by focusing strategically on the five "Cs" (Consumers, Competence, Cost, Communicating, and Connecting), there is a good chance that rural mental health will fare better in the year 2000 and beyond.

# The 5 “Cs” for the Next Century: A Strategic Focus

**Consumers:** Rural mental health is far behind its urban counterparts in encouraging and supporting consumer participation. Rural consumers do not have the same support, leadership, and participation opportunities that are available in urban settings. Consumer and family involvement is not only the right thing to do, it is essential for the success of rural mental health. Greater support must be demonstrated to ensure consumer and family involvement in decision making at all levels (clinical, program, policy) in rural mental health. There is a need to find and support consumer and family advocates who can clearly articulate the rural mental health experience to policy makers at the local, state, and national levels.

**Competence:** Rural mental health practitioners must develop and maintain a high level of clinical, service delivery, practice management, and cultural competence and be recognized for the unique competence they possess in rural mental health practice. A wide variety of new mental health technologies, financing mechanisms, clinical interventions, and approaches to service delivery are emerging. Rural mental health and substance abuse professionals must learn to effectively treat persons with co-occurring mental health and substance abuse disorders. These will need to be adopted to the uniqueness of rural settings and populations and mastered by rural mental health practitioners. It is also critically important that rural mental health practice be recognized by funders (insurance companies, States, foundations, etc.), regulators, and professional associations as requiring a specialized set of knowledge, skills, and abilities. This “rural practice expertise” includes the additional unique set of knowledge, skills, and abilities, beyond the normal professional training and credentialing that mental health practitioners need to successfully deliver services in rural settings and meet the needs of rural consumers. In the same way that all mental health professionals need to attain cultural competence, rural mental health practitioners (and programs) need to attain rural community competence. This specialized area of expertise must be clearly delineated and a mechanism developed whereby practitioners can be recognized as possessing rural mental health practice competence. In addition, it must be ensured that the credentialing standards of professional associations, licensing boards, and provider organizations (e.g., managed care companies) are consistent with rural realities. Finally, “best practices” for rural mental health service delivery need to be identified, documented, and disseminated.

**Cost:** Increased understanding and effective management of the cost of providing rural mental health and substance abuse services is central to the survival and growth of the fragile infrastructure of these services that currently exist across the country. Rural mental health providers require knowledge, skills, and abilities to operate successfully in managed care and capitated environments and to participate as full partners in behavioral health and general health care networks. In other words, providers need to understand the costs of all aspects of service delivery and determine how they can achieve efficiency in the delivery of services. In many cases, this means being able to estimate what it would cost to design and operate a rural mental health system that was truly accessible and responsive to the needs of rural citizens.

**Communicating:** Increased communication of the successes in rural mental health as well as the negative impacts that the changes in public policy or financing have on rural mental health is essential. A number of rural mental health programs have found successful and innovative ways to meet the needs of their clients. The field of rural mental health has, however, done a rather poor job of making those programs known nationally and sharing that knowledge among other rural mental health providers. The field is also woefully ignorant of the very specific ways in which changes in public policy or new financing mechanisms (e.g., managed care) affect rural mental health consumers and providers. Sharing knowledge and experience will make the field stronger. Finally, mental health and substance abuse organizations (including NARMH), providers, and professionals will have to decide whether to adopt the label of “behavioral health”.

**Connecting:** The rural mental health community needs to focus on connecting electronically, organizationally, and politically. Rural mental health consumers, family members, and practitioners need to be

electronically connected with each other and outside resources. They must be able to use those connections to support each other and to leverage the resources required to effectively respond to the needs of rural persons who experience substance abuse and mental disorders. The emergence of health networks in rural areas is an additional impetus for rural mental health providers to examine their organizational relationships and determine with whom they need to partner organizationally to sustain their mission. Finally, rural mental health advocates need to develop strategic partnerships with others (e.g., rural health advocates) to effectively develop and deliver a political agenda.

# Recommendations for Rural Mental Health

While many actions can be taken to improve rural mental health, the 5 “Cs” frame high-leverage strategies capable of enhancing rural mental health now and in the years to come. With the 5 “Cs” serving as a guide, a series of recommendations were developed which comprise the foundation of a strategic plan for rural mental health. Implementation of these recommendations will realistically take several years. However, they anticipate logical, realistic end-states where rural mental health service delivery should find itself in the years beyond 2000. The only way a unique rural mental health and substance abuse service delivery system can survive is if all constituency groups band together to advocate for a reasonable and affordable rural agenda. During this period of rapid change, with federal and state governments redefining service delivery models, fragmentation of advocacy efforts will certainly lead to a less optimum outcome. The ultimate goal of this report is movement towards a functional service delivery system that effectively meets the unique mental health and substance abuse needs of those in rural and frontier areas and can be supported in our rapidly evolving fiscal environment.

- **Rural consumers and families should collaborate to develop and employ strategies to ensure that their needs and realities are adequately addressed.**

To operationalize this recommendation, efforts will be required in several areas. Rural consumers and families must be full participants in planning and program development. Services should not be planned or created without consumer and family input and agreement. In the related area of contract development, consumers and families should advocate for standards and performance criteria that are specific to rural and frontier areas. When contracts are developed, outcome and process indicators should be included that make sense in low-density population areas. In addition, consumers and families should advocate for contract language that ensures adequate service delivery in less-populated areas, especially when state-wide contracts for behavioral health care services are being considered.

To ensure their active participation, at least two adjustments must be made to how the mental health system typically conducts business. First, rural mental health professionals and programs need to acknowledge the importance of consumers and families, and share power. This must be a conscious decision, and care must be taken to assist consumers and families to understand and utilize this power. Second, systems and programs must allocate resources so that consumers and families are able to be involved. If funding to support active participation is not available, their involvement can not occur. Consumers and families rarely have the personal means to support their interests. Only if these two changes are made can true collaboration occur and can consumers and families become empowered to develop and employ strategies to ensure that their needs are met and their realities are adequately addressed.

- **Recovery principles are critical and should be an underlying premise in the evolving mental health system.**

Adoption of the recovery model requires adjustment from all aspects of the rural mental health service delivery system, as well as the consumers and families served by the system. It is important that a shared vision of recovery be developed, which includes at its core an understanding that recovery is possible for all consumers and that personal responsibility is the key to recovery. Recovery is a lifelong process, not a cure. It is progressive, but not linear. Recovery is not rehabilitation, it is not skill-based, but it is rather a unique, individual process. Recovery requires a true partnership and collaboration between consumers and professionals. Adapting recovery principles to rural America requires thoughtfulness and creativity.

Recovery principles must be operationalized in the rural mental health service system and should include at a minimum: (a) the hiring of consumers as peer specialists; (b) the provision of education to consumers, families and significant others; and (c) reasonable access to paid consumer/family advocates who will be available to participate in service planning and in the grievance process. Funding streams should

support recovery principles that are adjusted to rural realities. For example, some managed care organizations will not pay for peer support programs unless these occur on-site and face-to-face. In remote areas, outcome data has demonstrated that peer support programs can be effectively delivered by phone or e-mail, eliminating the need for time-consuming travel and increasing the frequency of contact. Funding needs to directly support the development of this type of capacity.

- **Credentialing standards and processes should be consistent with the realities of rural service delivery.**

In the evolving mental health system, there must remain an identified role for mid-level providers who are more often found in rural and frontier areas. The shortage of licensed professionals in these areas is well-established and must be recognized by policy-makers. In many instances, an organization or practice group, not the individual practitioner, should be the credentialed entity. Continuation of effective service provision is contingent upon a rural-responsive credentialing process which allows for continued service provision by mid-level clinicians, and for the reimbursement of services provided by peer-specialists. For this to occur there should be developed a certification process, specific to the provision of rural mental health services.

If the individual must be credentialed, then the process should be competency-based as opposed to degree or licensed-based. Mid-level rural providers often have special knowledge and skills that should be recognized.

- **Technical assistance should be expanded specifically targeting the needs of rural America.**

Federal agencies, such as the Center for Mental Health Services, that provide technical assistance to systems of care and individuals, should develop and provide technical assistance programs that target the needs of rural consumers, families, programs and providers. These should include, but not be limited to: provision of culturally competent care in rural environs; application of recovery principles in rural America; and fiscal competence for rural managers and practitioners who must function in a managed care environment. Technical assistance must be fully accessible to the field. Centrally located training efforts often miss most rural providers. In addition, the process whereby technical assistance is procured should be re-visited. Many rural practitioners and mental health centers do not possess the resources to complete the lengthy and complex applications required to secure technical assistance.

- **Rural specific methodology for financing mental health and substance abuse care should be developed.**

Limited discussions have occurred regarding various concepts such as health insurance cooperatives, low population risk-based models, shared urban - rural/frontier risk pools, and public/private partnerships. With the decline in rural property values and an increase in delinquent property tax levels, the current financing of many rural public mental health services is unstable.

Several states no longer want to be service providers, but would prefer to be purchasers of care. Various states have debated the alternative of allowing state funded and operated programs to become semi-independent public benefit corporations. These are but a few of the critical funding issues that require careful consideration. Currently, there is no generally accepted method for financing mental health and substance abuse care in rural/frontier areas. This issue is of enormous concern given trends toward capitation and statewide contracts for behavioral health care services. Thorough investigation of the various alternatives should occur.

- **Rural mental health service providers should examine their cost structure and productivity data.**

Issues of cost and productivity are important to rural providers who must deal with geographic,

transportation, and care delivery issues that can adversely affect productivity. Providers must be cognizant of their true costs and actual clinician productivity. Providers should be confident that they have identified the true cost of producing a particular therapeutic outcome. This information should be utilized to develop a market-driven strategy that will allow them to compete in the new, behavioral health care environment, where the relationship between value and cost is a key principle.

- **Data should be available and analyzed separately for rural areas and for distinct groups within those areas.**

As statewide contracts for public mental health service provision become commonplace, policy makers must ensure that they can accurately assess program effectiveness. In the past, data pertaining to access, utilization, appropriateness, outcome and prevention has often been aggregated on a statewide basis, combining information from urban and rural/frontier areas. When combined, rural and frontier-specific findings can be masked by the larger urban population base. Even prior to analysis, policy makers, consumers, and service providers should establish what rural and frontier-specific data should be collected. While service integration and statewide contracts may become the norm, an ability to accurately assess the impact of changing mental health delivery models must be retained. In a similar vein, managed care company report card data should also be presented separately for rural, frontier, and urban areas.

Beyond a comparison of rural and frontier to urban, there should be recognition that there is no single type of rural setting. Significant sub-populations should be included in the planning and development of all services, and should be considered when data is being analyzed. When collecting data, these groups should be examined for differential experiences with respect to access, satisfaction, service utilization and grievances.

- **Service providers should utilize rural community resources to their fullest extent.**

The rural community continues to be the most important resource for the rural mental health practitioner. Given the scarce resources in most rural areas, rural mental health professionals need to leverage and maximize community resources to achieve the outcomes wanted by consumers, families, and funders. There exists a need to leverage community resources so as to make the community a responsible place which fosters support, habilitation and recovery with help from professionals but without dependency on them. This use of community resources should not be seen as a fallback because professionals are not available, but rather seen as representing a powerful and unique opportunity available in rural areas. It should be noted that the specialized ancillary programs (housing, vocational rehabilitation, etc.) available in urban settings are often not available to rural consumers. In many ways, rural mental health professionals are chefs who bake from scratch, putting together from the raw material of the local community the supports, opportunities, and help that clients need to be successful. Rural mental health professionals are expert at using full community resources and assets as instruments of recovery for persons with mental and substance abuse disorders.

- **In rural areas, mental health services should effectively interface with the primary care network.**

Given persistent limitations in the availability of specialty mental health services and practitioners, rural primary care providers are especially likely to play an expanded role in the identification and treatment of mental health problems. Rural mental health providers must effectively interface with the primary care system to bring services to those in need. If integration with primary care becomes the dominant model of mental health service delivery, careful planning must occur to ensure that the results are not fragmentation, increased discontinuity, or decreased efficiency. Integration should reduce, not create, barriers. Bird et al. (1995) caution that while integration of primary care and mental health services is a “policy ideal,” it remains an ill-defined concept that enjoys wide spread acceptance and face validity in the absence of evidence that it can fulfill many

of the expectations attributed to it. While integration presents challenges, so do carve out programs, since in this case data indicates that mortality rates for recipients of mental health services are significantly higher. In situations where integration with primary care is not required, rural mental health practitioners must be concerned with how they can actively relate with primary care professionals. Telehealth technology, now far more available and affordable to rural practitioners, could be employed to provide this support.

- **Rural clinics and providers should fully integrate technology into the way they do business.**

Rural clinics and providers seem to believe that because they are sincere, committed, and doing good work, they will survive unaffected by the myriad of technological changes sweeping the country. In a modern behavioral health care environment, those who will survive and prosper must be able to effectively manage information, understand their costs, and increase their efficiency. Organizations that develop and maintain a management information system that is dynamic, interactive, and capable of providing essential data whenever it is required, will be at an advantage.

An additional form of technology that can serve to increase the efficiency of rural mental health operations is telehealth. With regionalized services in rural and frontier areas, telehealth can both significantly decrease time lost to travel and effectively address some of the access issues created by program closure or consolidation. With the availability of desktop units, and greater access to specialized phone lines, many rural programs can now implement remote site programs. While this technology is affordable and can serve to increase efficiency, it is important to realize that it is not a panacea. It is not a quick fix for all the resource issues that confront rural providers.

## Conclusions

Rural mental health providers need to reflect more on what it means to deliver services in rural America. Rural mental health consumers, family members, practitioners, providers, and advocates need to make a personal commitment to set time aside in their busy schedules for rural mental health. Everyone needs to do something for the field, through active leadership locally, at the state level, or nationally. Central is the active support of and participation in rural mental health. Rural providers need to align themselves with other rural advocates to address rural mental health and substance abuse issues.

Rural mental health consumers, family members, practitioners, providers, and advocates must avoid the trap of focusing on general mental health issues. While working on general mental health issues, such as achieving parity between mental health and physical health care, will benefit rural mental health, it is not a strategic use of limited time. Individuals in rural mental health have very limited resources and opportunities to influence public policy. By speaking to general mental health issues we are a voice among thousands, unlikely to make a difference one way or another. The focus must be kept on rural. The issues addressed must be specific to rural mental health and to ensuring that policy decisions about general mental health do not adversely affect rural mental health consumers or providers.

## Appendix A

### Focus Group Members

Catherine Britain  
Consultant  
E. Oregon Human Services Consortium  
LaGrande, Oregon

H. Ed. Calahan  
Director of State Operated  
Community Services  
Texas Dept. of MH/MR  
Austin, Texas

J. Rock Johnson, JD  
NAMI Board of Directors  
NAMI Consumer Council  
Lincoln, Nebraska

Ronald Manderscheid, Ph.D.  
Project Officer  
Div. of State & Community Systems  
Development  
Center for Mental Health Services  
Washington, D.C.

Teri Sanders  
Regional Family Advocate  
Flagstaff, Arizona

Roger Strauss, Ph.D.  
Director  
Washington County VT MH Services  
Montpelier, Vermont

Peter Beeson, Ph.D.  
State of Nebraska  
HHS Strategic & Financial Planning Div.  
Lincoln, Nebraska

Jeanne Fox, Ph.D., RN, FAAN  
Director  
Southeastern Rural MH Research Center  
Charlottesville, Virginia

Damian Kirwan  
Arizona State Director  
National Mentor Healthcare INC.  
Mesa, Arizona

Harriet McCombs, Ph.D.  
Program Specialist  
Division of Program Development  
Special Populations and Projects  
Center for Mental Health Services  
Washington, D.C.

Donald Sawyer, Ph.D., MBA  
Co-Coordinator for Rural Affairs  
New York State Office of Mental Health  
Ogdensburg, New York

Henry Yenie  
Consultant  
Open Minds  
Gettysburg, Pennsylvania

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