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Rural and Frontier Mental and Behavioral Health Care: Barriers, Effective Policy Stategies, Best Practices

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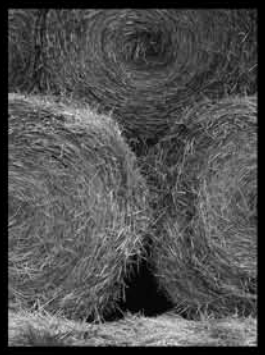






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Introduction:

During the late 1990's, the "Surgeon General's Report on Mental Illness" (1999) significantly increased awareness regarding the mental health needs of Americans. The report highlighted the prevalence of mental illness as the second leading cause of disability and the second leading cause of premature death in the U.S. In particular, it drew attention to:

> ...the immense burden of disability associated with mental illness. In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer (Murray & Lopez, 1996).

While the Surgeon General's Report covered many of the relevant issues and raised national awareness regarding mental illness, it only briefly touched on ***the mental and behavioral health needs of Americans living in rural and frontier areas***. More importantly, the report lacked detailed information on the issues, barriers, policy strategies and best practices that are relevant to the delivery of mental and behavioral health services in rural and frontier America.

In February of 2001, President George W. Bush announced his ***New Freedom Initiative*** to promote increased access to educational and employment opportunities for individuals with disabilities. During April of 2002, the President identified three obstacles preventing Americans with mental illness from receiving the care they require: 1) stigma; 2) unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance; and 3) the fragmented mental health care delivery system.

The President's ***New Freedom Commission on Mental Health*** was convened to investigate the problems and possible solutions in the current mental and behavioral health system. The Commission's findings confirmed that there are barriers and unmet needs which impede care for individuals with mental illness. The Commission reported that the vast majority of Americans living in underserved, rural and remote areas experience disparities in mental health services. Further, rural America makes up 90% of the landmass and has approximately 25% of the U.S. population (Bureau of the Census, 2001). The Commission concluded that: "Despite these proportions, rural issues are often misunderstood, minimized, and not considered in forming national mental health policy. Too often, policies and practices developed for metropolitan areas are erroneously assumed to apply to rural areas" (Commission Report, 2003). Due to the national scope of the review, the Commission's report was only able to briefly focus on rural and frontier, mental and behavioral health issues.

In the past thirty years, the research base has demonstrated that the problems of rural and nonmetropolitan America are unique and distinct from those of more urban and metropolitan parts of the United States. Rural areas (areas characterized by low population density, limited and fragile economic base, cultural diversity, high level of poverty, limited access to cities) have incidents of serious mental and behavioral health problems (depression, suicide, alcohol and substance abuse) equal to or greater than urban areas. Equally troubling is the insufficient volume and range of services available to treat mental and behavioral health problems in rural areas. Not only do rural areas have shortages of behavioral health professionals and specialized behavioral health services, but the turnover rate for service providers is high, and providers that remain often express feelings of isolation from other health professionals. These conditions are exacerbated in isolated rural and frontier areas and areas with concentrations of poverty and migrant and seasonal farm workers.

Current Project:

The current project was designed to build on earlier work and expand on issues identified in the New Freedom Commission's report. Specifically, the project consisted of a series of unstructured interviews with more than thirty individuals involved in mental and behavioral health services in rural and frontier America. In addition, over 200 NARMH members responded to a series of questions regarding the current status of rural and frontier mental and behavioral health. The information accumulated through these two approaches was used to prepare the current report which focuses on the following areas:

- Barriers to mental and behavioral health service delivery in rural America
- Model programs and effective activities for rural America
- Model policy strategies for rural mental and behavioral health care delivery
- The role telehealth should play in service delivery to rural America
- The role that State Offices of Rural Health and other state and local organizations should play in service delivery to rural America

In this report, findings regarding each of these issues will be considered separately. In each case, a comprehensive list of the points raised by respondents regarding the issue will be reported, followed by a brief discussion of that issue.

Issue 1: Barriers to mental and behavioral health service delivery in rural America:

The following issues were commonly identified by respondents as barriers to and concerns regarding service delivery in rural America:

Stigma and Cultural Issues

- Social stigma of mental illness
- Lack of rural-specific technical assistance
- Mistrust of health professionals in some rural and frontier communities
- Focus on illness care rather than on adequate early intervention and prevention
- Lack of cultural competence in spite of increasing diversity

Financing and Reimbursement

- Uncertainty of public funding streams
- Lack of flexible funding streams
- Lack of funding for prescription medication
- Complicated and cumbersome funding arrangements
- Restrictive reimbursement requirements, such as the need to have licensed professionals on staff to seek Medicaid/Medicare reimbursement, when private insurers will pay for services provided by case managers, etc.
- Lack of funding for evidenced based practices specifically for rural areas
- Reimbursement problems with telehealth services
- Funding systems are complex and fragmented leading to increased costs for providers
- Higher cost of service delivery in rural areas due to low volume of patients
- Managed care organizations place restrictions on providers

- Lack on insurance coverage for mental and behavioral health services or higher premiums or co-payments compared to other physical illnesses

Structural and Organizational Issues

- Insufficient communication among primary care providers and community mental health centers
- Incompatible software or hardware and inadequate infrastructure for telehealth connections
- Limited availability of clinicians with prescriptive authority
- Lack of specialists, especially those with child/adolescent expertise
- Lack of public transportation
- Distances and difficulties accessing care even when transportation (private) is available
- Lack of coordination among Federal Agencies, especially HRSA and SAMHSA
- Professional specialization interferes with adequate "life management" needs
- Lack of integration of mental health and primary care in many areas
- Lack of integration of mental health and substance abuse services
- Difficulties faced by rural providers when competing for funding, such as a lack of organizational capacity/expertise, the use of urban criteria for contracts (i.e. levels of required credentialed professional staff) by government agencies, etc.
- Lack of support for care givers, professionals and families (i.e. affordable housing, comprehensive rehabilitation programs)
- Lack of peer support services and consumer led groups
- Lack of comprehensive needs assessment data specific to rural and frontier areas
- Unintended impact of Federal regulations (HIPPA)
- Unaddressed behavioral health care needs of rural women

Access and Workforce

- Lack of trained staff members/providers/clinicians
- Lack of availability of dual-diagnosis treatment
- Lack of telehealth services
- Lack of continuing educational opportunities (i.e. for RN's to become Nurse Clinicians with a psychiatric specialty and an ability to prescribe medications)
- Significant distances to service providers
- Excessive wait times before services are available
- Lack of financial incentives for professionals to work in rural areas
- Lack of scholarships and grants for training
- Poor in-service training of, and dissemination of information to, rural practitioners
- Inadequate prescription drug benefits, especially for the self employed

Discussion: The barriers to mental and behavioral health services in rural and frontier America have changed little over the past three decades. Several studies and projects have reported that resources have historically been concentrated in urban areas of the United States, and the limited availability, accessibility and acceptability of rural mental and behavioral health services have created serious consequences for individuals, families and State mental health authorities.

In addition, there has long been a tendency to think about the "ideal rural America" with its scenic mountain and desert vistas and postcard perfect farms. In reality, these areas represent only a portion of rural America. Many rural communities grapple with issues of substantial ethnic and cultural diversity, deteriorating infrastructure, pervasive poverty, limited employment opportunities, and declining population bases. As a

result, the tax bases of these communities have continued to decline. With dwindling populations and eroding economic bases in many rural and frontier areas, funding for public mental and behavioral health services has suffered. These services have been and will continue to be dependent upon public funding and support. Unfortunately, the budget crises plaguing most State Medicaid programs limit the level of available funding for mental and behavioral health services and will likely continue to do so for the foreseeable future.

Issue 2: Model programs and effective activities for rural America:

Outreach

- Farm Resource Center, Mound City, Illinois
- Para-professional outreach by trusted individuals native to the community

Primary Care and Mental Health Integration

- Las Clinicas del Norte, El Rito, New Mexico
- Family Medicine Center, Amarillo, Texas

Financing and System Reform

- Home and Community Based Services Waivers (Medicaid) - allows for accountability, flexibility and cost-based reimbursements
- Outreach Grants (Office of Rural Health Policy/HRSA) – projects with a rural focus; projects are locally defined; projects expand the continuum of care
- Rural Interdisciplinary Training Grants (Bureau of Health Professions)
- Area Health Education Centers for training and outreach
- Rural Health Clinics
- Children's Mental Health Grants that promote in-home services
- School Health Clinics as a model for service delivery in rural and frontier areas
- Iowa Rural Mental Health Initiative
- Social Security Disability Reform (Ticket to Work Legislation) - allows the mentally ill to retain Medicaid when they return to work
- Faith-based services, treatment and support
- Seeds of Hope Consortium

Innovative Community-Based Programs

- Washington County Mental Health Services, Montpelier, Vermont
- Lake County Mental Health, Lakeview, Oregon
- Monroe Center and FMRS Mental Health Council, Union, West Virginia
- Tri-County Community Mental Health Center and Migrant Benevolent Association, Newton Grove, North Carolina
- 3-D Health Care Services, Milton-Freewater, Oregon
- Go-Teak, Elgin, Oregon
- Isabel Community Clinic and Professional Consultation Services, Isabel, South Dakota
- Laurel Health System, Wellsboro, Pennsylvania
- Community Mental Health Center Act

Workforce and Training

- Rural Psychiatry Program, Department of Psychiatry, University of New Mexico, Albuquerque, New Mexico

Discussion: Regardless of whether funding is sufficient or insufficient, there are rural and frontier models that work and that deliver culturally competent and efficacious care. Although these innovative programs exhibit a wide range of diversity in terms of where they are located and how they are organized, most share a common theme – the need to make better use of limited resources in rural communities. The bottom line is that there needs to be a consistent way to fund and promote the models that have proven outcomes, can be considered evidenced based "best practices" and can be replicated across a variety of rural communities. Too often innovative rural and frontier model programs are lost after a grant expires or a reimbursement stream ends.

Issue 3: Model Policy Strategies for rural mental and behavioral health care delivery:

Financing and Reimbursement

- Cost-based approaches to funding - flexible; includes in-home services; includes non-hospital services; made directly to community organizations as opposed to passing through State agencies
- Agencies and workgroups that provide financial support for rural consumers
- Families and clinicians to participate in various projects, workshops and conferences
- Targeted funding that establishes culturally specific outreach programs coupled with delivery systems capable of offering broad spectrum professional care at appropriate levels
- Funding that addresses interdisciplinary service delivery (with primary and mental health overlap)
- Discretionary funding streams that allow state-by-state issues to be addressed in geographic and culturally specific models, coupled with a reasonable degree of Federal oversight to keep clear and appropriate outcomes

Developing Rural Specific Programs and Services

- Federal staff serving as internal rural advocates and experts in agencies
- Culturally sensitive case workers (not only ethnic and racial but situational, i.e., those familiar with farm families and issues)
- Target initiatives in specific states or regions that combine information, education and counseling to improve access
- Rural specific data/research training
- Technical assistance and direct funding that supports rural organizational development and effective program operation

Enhancing the Functioning of Existing Services

- Focus on team/interdisciplinary and cross-trained personnel
- Requirement that dual-diagnosis be considered with ALL consumers
- Active communication between administration and providers
- Provision of toll-free crisis phone services
- Culturally sensitive case workers
- Use of Certified Nurse Clinicians with prescribing privileges to compensate for the lack of psychiatrists
- Involvement of consumers in all aspects of planning, evaluation and delivery of services
- Consideration of appropriate uses of alternative forms of therapy

- Support for pilot and model program development coupled with information dissemination and professional training opportunities

Discussion: Policy strategies that work are those with a specific, well developed rationale, that address rural and frontier realities. When considering funding policies, they are most often those that are cost-based, flexible, and include in-home, in-school, or other non-hospital services. Policies are best when funding is not passed through a State mental health authority, but is made directly to community based organizations or groups. In addition, those strategies with a rural-proven effectiveness allow providers to work through a variety of delivery mechanisms with a combination of licensed (MD, PhD) and case management (MA, BA) staff. In all cases, a national recognition of and commitment to rural and frontier is vital to the formation of "rural friendly" policies.

Issue 4: The role telehealth should play in service delivery to rural America:

Expanded Access to Clinical Services

- Avenue for regular access to training and continuing educational services
- Psychiatric consults when psychiatrists are not readily available
- Linkage and follow-up after discharge from an inpatient setting
- Discharge planning from inpatient services to community services
- Prevention and early intervention (i.e. crisis hotlines, referral and information clearinghouses, skills building, peer support)
- Provision of specialist support for the rural primary care providers

Enhanced Communication between Providers

- Multiple usages, such as 2-way audio-video; telephone; and IP connections
- Professional training
- Ongoing support for rural professional practice
- Provision of specialist support for the rural "generalist"

Enhanced Networking Opportunities for Consumers

- Group meetings for consumers as part of a recovery project

Discussion: For some time, those in the field of mental and behavioral health have heard that technology would revolutionize care, providing services from computerized case records and billing systems to off-site utilization review. In hospitals, technology has been shown to lead to statistically significant improvements in reduction of infection, accuracy of medication administration, and reduction of medical errors; however, in rural and frontier settings, the impact of technology is more elusive. The single area where improved patient care could be realized is in the significant expansion and active use of telehealth. Emerging technologies have made telehealth more affordable and usable. Telehealth can be used for long-distance clinical treatment, consultation, patient and professional education and administrative consultation. It is a greatly underused resource for mental and behavioral health services in rural and frontier areas. Policies and reimbursement methodologies would need to be adjusted to better support more comprehensive use of this intervention.

Issue 5: The Role that State Offices of Rural Health (SORH) and other state and local organizations should play in service delivery to rural America:

- Provide a quality assurance function by monitoring outcomes
- Provide consequences for wasting of public funds on technology that does not work and is not able to be utilized after a reasonable period of time
- Encourage open dialogue with providers and create an atmosphere of cooperation and collegiality
- Advocate on behalf of providers
- Create state plans that reduce or eliminate duplication and waste
- Advocate for evidenced-based issues that affect service delivery
- Advocate for and recommend policies that increase access to care
- Promote inclusiveness with consumers (real and honest involvement); provide funds for consumers to travel to meetings with funding for child care if necessary
- Promote the development of local organizations which support the mentally ill

Discussion: There is hope that State Offices of Rural Health can become a driving force behind developing networks and collaborations of relevant organizations to improve services and increase patient access. State Offices of Rural Health are essential partners, bridging primary care and mental health systems together, targeting program delivery to specific databased state and local needs, and encouraging collaborative partnerships. They are important in identifying and establishing linkages with undeserved populations and connecting local peer-type programs with State and Federal systems for such undeserved groups. They can be helpful in partnering the administration and delivery of rural services, especially in pilot and model programs where delivery skills are high but administrative and general management skills may be lacking. Finally, they can be an essential player in information and model sharing at both the state and regional levels.

However, their current functioning, these office are a long way from achieving these lofty goals. In a survey of over 200 NARMH members (practitioners, administrators, consumers and family members), only 57 percent were personally aware that their state had an Office of Rural Health, just 33 percent were knowledgeable about the function of their Office of Rural Health, and only 28 percent had ever interacted with the Office.

SUMMARY

The themes of rural mental health remain constant. Mounting needs, a lack of available professional staff, and restricted/limited resources strain existing services and limit access to rural residents in need. Unique geographical and cultural challenges to service delivery hamper the effectiveness of current delivery models. Urban models and assumptions imposed by funding sources or regulators further hamper the efforts of providers to serve rural communities. State and national policy makers continue to operate under a consistent and pervasive misunderstanding of rural realities. As a result, they do not adequately account for these rural realities in the development of public policy and they perpetuate the tendency to seek a single policy solution to rural issues.

In spite of the need to innovate and reach out to rural people, most rural mental and behavioral health programs typically look like smaller, under-resourced versions of urban programs. Quite frequently, rural mental and behavioral health services are office-based practices located in moderately sized towns that see people on a one-to-one basis for outpatient sessions. Although funding streams, regulatory mechanisms, and training programs contribute to this problem, they are not solely responsible for the existing state of affairs. The rural mental health community has not developed or sufficiently advocated for innovative and replicable evidenced-based solutions tailored specifically to the needs of rural citizens to serve as alternatives to the existing urban-based models.

Fortunately, there are effective mental and behavioral health advocates in many local, State, and Federal agencies and organizations that understand and have embraced the issues of rural communities. By virtue of their willingness to "go the extra mile," these key individuals and agencies have begun to move the field toward a better awareness of the mental and behavioral health needs of rural Americans and the challenges of serving them. Our challenge is to build on their efforts and maintain the momentum that they have created.

In order to do this, we must address and move beyond the problems briefly addressed by the Surgeon General and the President's New Freedom Commission. This will require State and Federal policymakers, providers, consumers, and mental and behavioral health advocates working together to forge an ongoing national rural mental and behavioral health agenda that enables these services to operate in the health care mainstream by:

- Incorporating policies specifically tailored to the needs of rural communities, providers, and consumers;
- Providing the resources and tools needed to appropriately deliver services in rural areas in a culturally sensitive and competent manner; and
- Developing evidenced-based models of care that are both replicable and transferable across a range of rural communities.

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