

NEW FREEDOM COMMISSION ON MENTAL HEALTH

Subcommittee on Rural Issues:

BACKGROUND PAPER

June 2004

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Disclaimer

The content of this publication reflects the views and opinions of the Subcommittee on Rural Issues. Therefore, this paper is a product of the process that advised the full Commission and as such does not reflect the position of the President's New Freedom Commission on Mental Health or any agency of the United States Government.

Preface

The President's New Freedom Commission on Mental Health appointed 15 subcommittees to assist in its review of the Nation's mental health service delivery system. The full Commission appointed a Chair for each subcommittee. Several other Commissioners served on each subcommittee, and selected national experts provided advice and support. The experts prepared initial discussion papers that outlined key issues and presented preliminary policy options for consideration by the full subcommittee. The subcommittee reported to the full Commission only in summary form. On the basis of this summary, the full Commission reached consensus on the policy options that were ultimately accepted for inclusion in the Final Report, *Achieving the Promise: Transforming Mental Health Care in America*. Therefore, this paper is a product of the subcommittee only and does not necessarily reflect the position of the full Commission or any agency of the United States Government.

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Introduction

People in the United States experiencing health crises routinely encounter a sophisticated health care response system. From the first-responders to rehabilitation providers, people typically encounter well-trained health care professionals and systems of care. The system, personnel, and practices operate pretty much the same whether the need for care is encountered in Washington, D.C., or Chadron, Nebraska, varying little from the inner city to a small rural community. However, this is not the case for mental health care, particularly in rural settings.

As a result, the Subcommittee on Rural Issues finds a confluence of issues relating to rural mental health accessibility, availability, and acceptability that create critical barriers to care for the 25% of Americans who reside in non-metropolitan areas across our nation. These barriers result in an “experience of care” for rural Americans that too often includes a delay in care, inconsistent care, or no care. The facts are clear:

- Although rural Americans’ prevalence and incidence of mental disorders is comparable to their urban counterparts, they are much less likely to have access to services or providers (Lambert & Agger, 1995).
- Rural teens and rural older adults have a much higher rate of suicide than do their urban peers (Eberhardt, Ingram, & Makuc, 2001; Institute of Medicine, 2002; Stack, 1982; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994).
- Rural residents are less likely to have health insurance with a mental health benefit, and financial resources available to support mental health systems are less robust (Mueller, Kashinath, & Ullrich, 1997).

- Programs to specifically train and promote the placement of rural mental health professionals are not available, and those that do exist are often not located in rural areas (Bird, Dempsey, & Hartley, 2001; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994).
- Federal agencies tasked with mental health public policy, research, and services support lack any systemic structure for coordinating their efforts.

Rural America makes up 90% of our nation’s landmass and is home to more than 25% of our nation’s people.

This Subcommittee paper elaborates on a range of uniquely rural issues and policy options. The broader issues of mental health expanded upon by the Commission’s other subcommittees also apply to rural mental health. It is critical to understand that there is no “one rural America,” nor can there be a single Federal rural mental health response. Instead, rural America exists in many places and its hallmark is its great diversity of people, challenges, and opportunities.

The Subcommittee on Rural Issues contends that one policy option is paramount: **rural Americans should be provided the same access to mental health emergency response, early identification and screening, diagnosis, treatment, and recovery services as their non-rural peers.**

Rural America makes up 90% of our nation’s landmass and is home to more than 25% of our nation’s people. While rural places and people (regardless of the definition of rural used) exist in every State and territory of the United States, rural mental health is too often not taken into

account (U.S. Health and Human Services [HHS] Rural Task Force, 2002). Frequently, policies and practices developed in and for people in metropolitan environments are assumed to apply to the rural population.

Epidemiologic evidence suggests that the prevalence and incidence of adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) are similar between rural and urban populations (Kessler et al., 1994). However, access to mental health care, practitioners, and delivery systems to provide care, and attitudes and cultural issues influencing whether people seek and receive care differ profoundly between rural and urban areas.

A long and somewhat unproductive debate has occurred over whether and how much “rural” mental health differs from “urban” mental health. Citing the absence of a clear difference in rural-urban prevalence rates, some people argue that we simply need to get more psychiatrists to

practice in rural areas. While this solution would help, it has not and is not likely to happen; it overlooks the profound rural-urban differences in access, infrastructure, and cultural issues.

(For an excellent discussion of the research literature on rural-urban differences, see Rost, Fortney, Fischer, and Smith, 2002. For an insightful discussion of the policy importance to recognize and understand rural-urban mental health differences, see Hartley, 2002.)

This paper first discusses issues about how *rural America* is defined and relates important implications for providing mental health care. The paper then reviews epidemiologic evidence of rural behavioral health. Challenges and opportunities for caring for rural Americans are then presented in terms of accessibility, availability, and acceptability. Throughout these discussions we offer policy options aimed at eliminating barriers to mental health care for rural Americans.

Defining Rural America

Many definitions of *rural* exist, often leading to confusion. The Department of Health and Human Services (HHS) Rural Task Force's *One Department Serving Rural America* observed the significance of this problem (HHS, 2002). The task force noted that HHS lacks a common definition of *rural* or even a commonly shared set of definitions. The result, the report noted, makes it "difficult to target grants, evaluate services, develop policy, and quantify HHS investment in rural and frontier communities" (p. ii).

POLICY OPTION 1

The Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) is urged to convene an expert panel to identify and recommend a single rural definition that is then applied consistently across all SAMHSA programs.

The U.S. Census Bureau (see Census Bureau definitions at <http://www.census.gov/population/www/censusdata/ur-def.html>) defines *urban* as (1) central places with a population of 50,000 or more, together with contiguous territory having population density of 1,000 or more per square mile, plus (2) other areas outside these central places with a population of 2,500 or more. Areas not classified as urban are designated *rural*. Thus, rural areas are those comprised of places with fewer than 2,500 residents and open territory. Sparsely populated settlements, referred to as *frontier rural areas*, are defined as areas—including counties—having low population density, usually fewer than 6 or 7 people per square mile (Ciarlo & Zelarney, 2002).

The Office of Management and Budget (OMB) definitions of *metropolitan* areas and *non-metropolitan* areas are based on county types.

Metropolitan areas have:

- Core counties containing one or more central cities with at least 50,000 residents or an urbanized area and a total population of at least 100,000 (75,000 in New England); and
- Adjacent communities that have a high degree of social and economic integration with the core counties.

Non-metropolitan counties are those counties that are not defined as *metropolitan*.

The Department of Agriculture (USDA) has several methodologies to denote rural. The rural-urban continuum codes, urban influence codes, and rural county typology codes developed by the Economic Research Service (ERS) of the USDA allow standard metropolitan (urban) and non-metropolitan (rural) areas to be broken into smaller residential groups. Rural and urban may also be viewed as the opposite ends on a continuum—varying from the most rural to the most urban—and as exhibiting variations in population size and density, demographic and socio-economic characteristics, proximity to a central place, and accessibility to needed services (Hewitt, 1989).

The definition used does make a difference.

The OMB definition of metropolitan versus non-metropolitan (i.e., urban versus rural) excludes some very rural communities from qualifying for rural assistance programs. For example, when the OMB definition is used, San Bernardino County in California, which includes a portion of the greater Los Angeles area to the west and stretches eastward to include Death Valley (covering more than 20,000 square miles), cannot qualify for rural health and social service grants from HHS or for rural Medicare payment protections (HHS Rural Task Force, 2002).

Clearly, *one rural* does not exist in America. Rural America is diverse along multiple levels;

what is called for within HHS and state government is a formalized definition process capable of integrating that diversity.

Goldsmith, Holzer, Ciarlo, and Woodbury (1999) developed a system that goes beyond simple population-based definitions and uses a “Grade of Membership” (GOM) analysis of socio-demographic variables to identify “pure types” of rural and urban environments. The variables included are:

- Social rank (including economic, occupational, and educational status),
- Household/family composition,
- Housing,
- Mobility,
- Travel-to-work characteristics,
- Ethnicity,

- Local economic activities,
- Tax structure, and
- Expenditures for police and fire services.

Their GOM analysis accounted for 27 “pure” types of counties, each of which possesses specific patterns of demographic, economic, social, and health characteristics.

Such an analysis to determine rural versus urban may present a more effective tool to Federal and State health/mental health planners. For example, the variables (e.g., economic and social characteristics, ethnic backgrounds) would provide a richer data set to inform the process of planning for rural area initiatives around workforce development, recruitment, or program development than does a simple rural/urban designation.

Review of Rural Behavioral Health Epidemiologic Evidence

POLICY OPTION 2

SAMHSA, in collaboration with the National Institute of Mental Health (NIMH), is urged to ensure research is supported that seeks to improve the depth of knowledge available on the prevalence, incidence, and etiology of behavioral disorders across a wide array of rural environments, to better support the ability to precisely focus limited resources on specific areas of need.

The prevalence and incidence of adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) are similar between rural and urban populations (Kessler et al., 1994). Rural suicide rates are the major exception. Suicide rates for both rural adults and children are higher than they are for their urban counterparts, a trend that has been consistent for more than a decade (Institute of Medicine, 2002; Stack, 1982; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). The suicide rate is significantly higher among elderly males and Native American youth (Eberhardt, Ingram, & Makuc, 2001), and the rate of suicide appears to increase

the more rural the population. While several factors have been suggested as contributing, in-depth analysis and research has not been conducted in multiple rural settings.

As with mental illnesses, the overall prevalence of alcohol and drug abuse has repeatedly been shown to be comparable between rural and urban populations. However, some pockets of abuse have been noted for specific substances (e.g., methamphetamines, inhalants). Rural Native Americans do not differ from urban Native American populations in rates of alcohol abuse, which are higher than the population at large; however, rural Native Americans tend to have more episodes of binge drinking (National Rural Health Association, 1999; Weibel-Orlando, Weisner, & Long, 1984).

Mental disorders and substance abuse disorders often co-occur for both adults and children. (Regier, Farmer, Rae, et al., 1990). Evidence-based practices have been established for treating these co-occurring disorders (Drake, Essock, Shaner, et al., 2001). However, there is little research on the incidence, prevalence, and etiology of co-occurring disorders in rural populations. Thus, the field lacks an understanding of the need and how to tailor these evidence-based practices to treat persons with co-occurring disorders in rural areas.

Challenges in Caring for the Country

The prevalence and incidence of adults with SMI and children with SED are not different in rural and urban areas. What differs in rural America is the *experience* of individuals with mental illnesses and their families (Wagenfeld et al., 1994).

The different experiences that rural persons with mental illnesses face are influenced by three factors that may prevent them from receiving the mental health care they need:

- Accessibility,
- Availability, and
- Acceptability (Larson, Beeson, & Mohatt, 1993; Mohatt, 2000).

These variables lead rural residents with mental health needs to: enter care later in the course of their disease than do their urban peers; enter care with more serious, persistent, and disabling symptoms; and require more expensive and intensive treatment responses (Wagenfeld et al., 1994).

Accessibility

Three significant components of access to mental health services put rural residents at significant disadvantage: knowledge, transportation, and financing.

POLICY OPTION 3

SAMHSA, in collaboration with the Secretary of HHS and the Surgeon General, is urged to establish a public information initiative to increase rural residents' understanding of mental illnesses and best practices in treatment. This effort might be coordinated with local systems of care.

An essential element of access is knowing when one needs care and where and what care options

are available to address that need. In both respects, the rural experience differs from the urban one. The frequently noted myth of an idyllic rural existence persists (HHS Rural Task Force, 2002). This myth, when widely held, becomes a barrier to creating an impetus for action to address rural mental health problems.

The perception of need for care is the first step in seeking care, and rural residents seem to enter care later than do their urban peers due to a lower perception of need—a problem that is then compounded by their perceiving less access to care. Empirical studies show that lower rates of access to mental health services is directly related to lower rates of availability or supply of mental health providers (Lambert & Agger, 1995). The barrier to care posed by provider availability in rural areas is discussed further in the next section.

Current research suggests that perceived need for care in rural areas is so low that even minimal barriers in other areas can prevent a person from seeking assistance (Rost, Fortney, Fischer, & Smith, 2002). One response to overcoming these barriers is a marketing effort to enhance rural residents' knowledge of mental illnesses, treatment options/best practices, and local resources. Many have expressed their apprehension about creating an increased demand when current resources are often over-utilized. However, consumers, noting “they couldn't go because they didn't know,” believe public education and marketing efforts should be among the top priorities for enhancing the rural mental health care system (Ralph & Lambert, 1999).

Transportation

The ability to travel to services and to pay for those services if accessed is a significant barrier to rural Americans. Affordable and accessible (physically and psychologically) transportation services may be unavailable, especially to rural

children, people with disabilities, and the elderly. Public transportation is often not an option to rural consumers of mental health services. As a result, many rural mental health providers operate some form of transportation service to bring consumers to care—an operational cost not often incurred by their urban counterparts. Rural consumers and families must often travel hundreds of miles weekly to access care available only in larger communities that serve as “regional centers of trade.”

Rural Economy and Employment

Socio-economic factors play an important role in accessibility of services, and often these factors are not taken into account in formulating either policies or initiatives relating to rural mental health. Agriculture is important, but no longer central to rural economies. Just 6.3% of rural Americans live on farms, and 50% of these farm families have significant off-farm income. Farming accounts for only 7.6% of rural employment, and 90% of rural workers have non-farm jobs (U.S. Congress, 2002).

Rural employment is dominated by low wages, and rural incomes are less than those in urban areas. In 1996, 23% of rural workers were employed in the service sector and were nearly twice as likely to earn the minimum wage as were their urban peers (U.S. Congress, 2002). Compared to urban workers, rural workers are more likely to be unemployed and less likely to move out of low wage jobs, while rural families are more likely to be employed and still poorer than are urban families.

More than 25% of rural workers over age 25 earn less than the Federal poverty rate, and 600 rural counties (23%) are classified as persistent-poverty counties by the U.S. Government. Child poverty is higher in rural areas than in urban ones, and more than half of all rural children in female-head-of-households are in poverty (3.2 million children). Children of color are at particular risk, with 46.2% of rural African American children, 43% of rural Native American, and 41.2% of rural Hispanic children living in poverty (U.S. Congress, 2002).

Rural Population Movement

As for rural demographics, some places are growing, while many are not. During the 1990s, 2.2 million more people moved from the city to the country than vice versa, reversing a trend established during most of the 20th century. During this same period, 70% of rural counties grew in population; however, the pace of growth slowed over the span of the decade (U.S. Congress, 2002).

Since the mid-1990s, all rural counties (except rural commuter counties) have experienced reduced rates of population growth and the rural rate of growth is only half the rate experienced in urban areas. The Great Plains has experienced significant population loss, and depopulation, of many frontier (fewer than 6 people per square mile) counties (U.S. Congress, 2002). These population shifts, especially out-migration, strain the resources available to sustain comprehensive mental health systems.

Education

Rural educational levels continue to be less than those in urban environments. Fewer rural adults have a college education than do urban adults (15% versus 28%), and the number of rural adults without a high school diploma is greater than in urban areas (20% versus 15%). Fewer young adults in rural areas seek higher education. Since the high school graduation levels match or exceed urban levels, clearly these graduates are leaving rural America more often than are their non-graduating peers, making the “best and brightest” the chief rural export (U.S. Congress, 2002). This out-migration of capable young persons limits the pool of persons to potentially train as new mental health professionals.

Implications for Mental Health Care

The implications of these phenomena can have a significant bearing on rural mental health through limiting the following:

1. Supply pool of skilled individuals to staff mental health programs,
2. Availability of natural supports for people with SMI and children with SED,

3. Level of peer support and affiliations available to create and sustain an environment that supports professional recruitment and retention of mental health and allied staff, and
4. Financial resources available to support a continuum of mental health services (Gamm, Tai-Seale, & Stone, 2002).

POLICY OPTION 4	The Subcommittee proposes that SAMHSA, in collaboration with the Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth and NIMH, fund rural demonstrations of, and performance measurement of, Telehealth Mental Health Care for adults with SMI and children with SED. Requirements that promote enhanced coordination between funded telehealth systems and public mental health systems might be included in HRSA/Office for the Advancement of Telehealth (OAT) and other Federally supported telehealth projects.
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The emergence of telehealth strategies over the past decade has opened a new access point for many rural consumers, families, and systems. The use of telecommunication in the delivery of health services, consultation, and training in mental health is expanding rapidly. The field is very broad, spanning audio-only telephone or radio consultation and crisis intervention to very sophisticated interactive audio-video linkages between distant clinical and training sites.

A recent review and survey of current grantees under the Federal Office for the Advancement of Telehealth (LaMendola, Mohatt, & McGee, 2002) noted that the majority listed mental health as an area of service delivery. However, closer examination found that telehealth mental health care was a major component of less than a dozen projects, and few noted any formal link to the systems of care for adults with SMI or children with SED. Frequently, these projects

are organized around hospital and primary care networks that may lack strong collaborative traditions with the systems of care for adults with SMI and children with SED.

The study also found little data on telehealth mental health care performance beyond consumer satisfaction surveys and process measures. Telehealth mental health care has been held forth as a significant tool in improving the chronic lack of access to mental health services among rural populations. However, there simply are not enough data available to measure the ability of such telehealth strategies to enhance access for adults with SMI or children with SED.

POLICY OPTION 5	The Subcommittee encourages the Secretary of HHS to develop Federal policies that will enable rural individuals and small businesses to enter insurance-purchasing pools as a means to enhance access to more affordable health insurance options.
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Employment-based health insurance covers a wide variety of health services for Americans, and is the most common form of health insurance coverage in the United States, covering 64.9% of the non-elderly population and 34.4% of the elderly population in 1998 (McDonnell & Fronstin, 1999). Often, small employers do not offer a full range of benefits, and employers with 50 or fewer workers are exempt from the Mental Health Parity Act of 1996.

Retiree health benefits have steadily declined over the past decade, with only 30% of employers offering retiree health benefits in 1998, as compared to 40% in 1993 (McDonnell & Fronstin, 1999). A similar dramatic decline occurred for mental health benefits, where per employee expenditures for behavioral health benefits have gone from \$151.54 in 1988 to \$69.61 in 1997 (The Hay Group, 1998).

For rural Americans, the cost of health services (only partially reimbursed by Medicare Part B; or at discount by Medicaid) may be too

expensive—especially prescription drugs. Small group and individual purchasers, who often cannot afford comprehensive policies, dominate the rural health insurance marketplace. As a result, these policies often have large deductibles, and limited or no behavioral health coverage (McDonnell & Fronstin, 1999).

Rural residents also have longer periods of time without insurance than do their urban peers, and hence, a greater likelihood of pent-up demand. In addition, they are more likely not to seek physician services when they cannot pay, both because of pride and limited opportunities for free or reduced-fee clinical care (Mueller, Kashinath, & Ullrich, 1997).

POLICY OPTION 6	The Subcommittee proposes that SAMHSA, in collaboration with the Secretary of HHS, implement a study and tracking mechanism to monitor the relinquishment of child custody to obtain mental health treatment for children.
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Lack of insurance can be especially tragic for families with children with SED. Too often, parents face the unthinkable choice of relinquishing custody of their child to obtain mental health treatment because they cannot pay for care. It has been estimated that more than 25% of families face this crisis each year (Bazelon Center, 2000; NAMI, 1999). While the data are not extensive in this area, those data would suggest that rural families with lower rates of insurance coverage and provider availability may be at greater risk of facing this horrible dilemma.

POLICY OPTION 7	SAMHSA is urged to ensure that non-Federal matching fund requirements are not placed at levels unrealistic for rural entities competing for Federal funding opportunities.
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Rural mental health systems can rarely operate without direct or indirect governmental subsidy; this is especially true for programs serving persons with SMI or children with SED (Wagenfeld, 2000). However, unlike the

situation in general rural healthcare, specific Federal strategies for sustaining a rural mental health infrastructure do not exist (e.g., Community and Migrant Health Clinic Programs, Critical Access Hospitals). Finally, rural programs often operate in areas with disproportionately limited sources of financial resources to leverage as matching funds in seeking to compete for Federal and private foundation grant support.

Availability

The availability of rural mental health professionals depends on the complex interplay of education, rural training opportunities, recruitment and retention activities, and continuing education and support. Rural America needs competent, technically appropriate professionals who have demonstrated knowledge and experience in rural/remote practice.

POLICY OPTION 8	The Secretary of HHS is urged to convene a cross-agency work group to examine existing workforce enhancement programs and make recommendations for ensuring and enhancing their collaborative focus on rural mental health needs.
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Existing funding streams and training programs have missed the mark by not mandating a set of skills that would lead toward rural competency, developed in parallel with efforts toward establishing cultural and technical competency (National Advisory Committee on Rural Health, 1994). As a result, rural areas are experiencing serious shortages of health and behavioral health providers and programs.

Most specialty mental health (psychiatry and psychology) care is available regionally only in larger trade centers or locally only through periodic visits by itinerant providers (Wagenfeld et al., 1994). Over the past decade, many rural hospitals have closed or converted to Critical Access Hospitals providing more limited services, which has further eroded the basic rural health infrastructure.

Rural hospitals were less likely than urban hospitals to have psychiatric services before this development (Wagenfeld et al., 1994), and this further erosion likely worsens this problem. For rural Americans with mental health emergent needs, law enforcement is often their emergency responder and transport out of the community for care is the emergency response (Larson et al., 1993). This could be prevented with the availability of competent professionals to direct triage and stabilization.

More than 85% of 1,669 Federally designated mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001). The problem persists, with several reports dating from the Eisenhower-era Presidential Commission on Mental Health through today noting little improvement (Flax, Wagenfeld, Ive, & Weiss, 1979; Murray & Keller, 1991). Holzer and colleagues (2000) found that few psychiatrists, psychologists, or clinical social workers practice in rural counties, and that the ratio of these providers to the population worsens as rurality increases. For the past 40 years, approximately 60% of rural America has been underserved by mental health professions. Strategies to date have failed to make significant impact, and a fundamental change in strategy must be undertaken.

These workforce shortages are even worse for specialty areas, such as children’s mental health, older adult mental health, and minority mental health. The workforce shortages are so great it is identified as a “hole in the safety net” in a recent report to the Secretary of HHS (National Advisory Committee on Rural Health, 2002), and a “critical gap” in child mental health reform (Morris & Hanley, 2001).

The available data in this area are not as consistently monitored as in other areas of health care, and are made more complex by the myriad of State- and guild-driven policies associated with mental health practice. The available data portray a critical disparity in the availability of mental health professionals in rural areas. The National Advisory Committee on Rural Health (1993) noted that across the 3,075 counties in the United States, 55% had no practicing psychiatrists, psychologists, or social workers, and *all* of these counties were rural.

**POLICY
OPTION 9**

The Subcommittee encourages the Secretary of HHS to support an effort to articulate a rural mental health workforce strategy that includes a realistic use of and support of mid-level and alternative providers of mental health services.

While physician extenders effectively staff many rural primary care sites, to meet demand due to the difficulty in recruiting and retaining primary care physicians in rural communities, the mental health field has not developed an analogous mid-level strategy to meet the needs of rural people. Instead, mental health workforce policy has been focused almost exclusively on doctoral-level providers (i.e., psychiatrists and psychologists).

In the absence of clearly defined strategies, a de facto workforce strategy has been established. Rural systems of care have been staffed by an array of non-doctoral level providers, without any consistent standards or core competencies. Instead, staffing has been driven more by State scope of practice regulations and insurance reimbursement rules than by science or competency (Ivey, Sheffler, & Zazzali, 1998; Jerrell & Herring, 1983; Olson, 1983).

**POLICY
OPTION 10**

The Subcommittee proposes that the Administrator of SAMHSA ensure the support of programs that specifically support the training, deployment, and continuing education of rural mental health professionals. Such support might focus on strengthening the capacity and competency of the workforce to support an evidence-based practice care delivery system.

Education and training are critical missing links for addressing the issue of workforce shortages. This gap has been recently highlighted by the work of two national organizations—the American College of Mental Health Administration and the Academic Behavioral

Health Consortium. These two organizations hosted a national meeting in the fall of 2001 in Annapolis, Maryland, sponsored by SAMHSA. The meeting has grown into an ongoing effort known as the Annapolis Coalition on Behavioral Health Workforce Development. The initial work of the Coalition has been published as a special double-issue of a prominent mental health journal (Hoge & Morris, 2002).

POLICY OPTION 11	The Subcommittee proposes that SAMHSA, in collaboration with NIMH, initiate and support research to identify, verify, and disseminate evidence-based practices suitable for rural practice environments. Resources could be made available to support transferring this knowledge to rural providers and systems of care.
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As the system increasingly emphasizes and supports evidence-based practice, little attention has been shown for supporting workforce development activities to enable rural mental health providers and systems to adopt these new methods. The past two decades have seen a steady elimination or reduction of programs that specifically support training rural mental health professionals (Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). While NIMH provided a considerable degree of support for professional education in the 1970s and early 1980s, this support has declined (Bird, Dempsey, & Hartley, 2001).

POLICY OPTION 12	The National Health Services Corps (NHSC) is urged to include Master's-level psychologists, social workers, and counselors in their loan repayment and scholarship programs, as these professionals are most likely to locate and be retained in rural underserved areas.
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HRSA administers two programs that have recently attended to the needs of underserved

rural persons with mental health needs: the NHSC and the Community and Migrant Health Centers Program. Several other HRSA programs also focus resources on meeting mental health workforce needs (e.g., Quentin N. Burdick Rural Health Interdisciplinary Program, J-1 visa waiver program).

These programs have made a modest impact on the chronic professional shortage problems in rural America. For example, from 1995–1999, the NHSC placed 244 mental health professionals (NHSC does not support training and placing Master's-level psychologists and mental health counselors) (Bird et al., 2001).

POLICY OPTION 13	The Secretary of HHS is encouraged to explore the creation of a limited program—similar to the former Community Mental Health Centers Act—to provide a basic safety net continuum of rural mental health care for underserved areas. The Subcommittee advises that this program ensure integration with the Community and Migrant Health Centers program and provide for an alternative financing strategy for rural mental health.
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More recently, the current and ongoing support for expanding the Community and Migrant Health Centers program to include mental health services is both an opportunity and a challenge. The effort could potentially strengthen and expand access to mental health services through these Federally Qualified Health Centers (FQHCs); however, HRSA has not required ample coordination and collaboration with existing community mental health agencies. As a result, this expansion may lead to duplicated effort and recruitment of staff for this expansion from existing community programs, shifting costs for recruitment to these community agencies that do not have the Federal subsidy of the FQHCs.

Acceptability

POLICY OPTION 14

The Subcommittee proposes that the Secretary of HHS require a “rural impact statement” of all behavioral health rules, policies, and initiatives within the department retrospectively and prospectively to ensure rural equality of access.

Stigma is a major barrier to receiving proper care. Rural residents tend to view help-seeking for mental health services more negatively than do their urban peers. They also have a more limited level of knowledge about available services and resources (Rost et al., 2002). Providers’ cultural competence is a major issue for racial and ethnic minority populations seeking assistance, but “rural cultural competence” receives little policy or training attention. Ethnic and minority populations are often unable to access providers who are of their ethnic/racial group, speak their language, or are knowledgeable of their cultures (Martin, 1997; U.S. Public Health Service Office of the Surgeon General, 2001).

A recent survey of rural mental health outreach programs conducted by the National Association for Rural Mental Health found that even the best programs felt unprepared to meet the cultural and clinical challenge of reaching out and engaging recent immigrants to rural areas (Lambert et al., 2001). Many rural providers are not rural natives, are trained in urban-centered models and programs, and travel to rural practice from metropolitan areas on an itinerant basis, creating a rural knowledge gap (Keller & Murray, 1982; Larson et al., 1993).

Public mental health policies and programs are routinely based on urban models and experiences and are scaled down to fit the rural environment (Bergland & Dixon, 1988; Gamm et al., 2002; Larson et al., 1993; Mohatt, 2000). The challenges and pitfalls of adapting one significant intervention—assertive community

treatment—have been well documented (Lachance, Deci, Santos, & Halewood, 1996; McDonel et al., 1997; Santos, Deci, Lachance, et al., 1993).

POLICY OPTION 15

The Administrator of SAMHSA is urged to establish an Office of Rural Mental Health and a National Advisory Committee on Rural Mental Health, specifically staffed and tasked to exclusively coordinate SAMHSA activities relating to rural areas and ensure coordination with other HHS offices relating to those rural areas.

In the dearth resulting from rural-specific policy and planning falls the shadow of assumption. Too often these assumptions are based on urban experience, and when applied to rural America, they simply do not fit. Beeson, Britain, Howell, Kirwan, and Sawyer (1998) produced Figure 1, which clearly articulates some of these differences between urban assumption and rural reality.

General health care planners and policymakers have embraced the notion that “one size does not fit all,” demonstrated by a comprehensive strategy to employ mid-level physician extenders to address underservice and to create delivery structures that fit the realities of the rural marketplace. FQHCs operating in areas of underservice are reimbursed on a cost basis and receive an ongoing Federal subsidy to counterbalance the disproportionate number of uninsured served and the general lack of a payer base; no such strategy exists for rural community mental health agencies.

Another example of policy and action meeting rural reality is the development of Critical Access Hospitals, which allow for alternative staffing and reimbursement of small rural hospitals, a program that has enabled hundreds of rural communities to preserve their local hospital. Once again, no analogous strategy in mental health exists.

**POLICY
OPTION 16**

The Secretary of HHS is encouraged to require the creation of a SAMHSA Rural Mental Health Plan, with specific targets (similar to *Healthy People 2010*), as a means to establish a rural mental health benchmark and method for gauging progress.

Finally, while specific attention on rural health has risen to the level of importance warranting the establishment of both the Federal Office of Rural Health Policy and a National Advisory Committee on Rural Health within HRSA, a similar focus is not present in SAMHSA. With the exception of the NIMH Office of Rural Mental Health Research, no bureau, division, or staff member is exclusively devoted to rural mental health issues.

The implication of this lack of attention is manifested in many ways and has been noted in many reports issued over the years relating to rural mental health (Bergland & Dixon, 1988; HHS Rural Task Force, 2002; Larson, Beeson,

& Mohatt, 1993; Pion, Keller, & McCombs, 1997). For example:

- Short response times for Grant Funding Applications and Requests for Proposals that put rural programs with human resource shortages at a disadvantage in assembling the resources required to prepare a competitive submission;
- Matching fund requirements that do not take into account the available resource pool in rural markets (e.g., programs on Native American reservations that are required to show the same non-Federal match as all programs, when most health resources available are Federally funded);
- Lack of research and demonstration of rural-specific evidence-based practices;
- Continued focus on specialty-driven practice and policy, when the rural literature supports a generalist model (Pion, Keller, & McCombs, 1997); and
- The assumption that metropolitan-tested policies and practices only need to be “downsized” to fit rural area needs.

FIGURE 1: MENTAL HEALTH PRACTICE: URBAN ASSUMPTIONS AND RURAL REALITIES

	URBAN ASSUMPTION	RURAL REALITY
Specialized Mental Health Services	There is duplication and lack of coordination and integration of services.	There is a lack of availability of services but effective (informal) coordination and integration of existing services.
Resources	Resources would be adequate if they were managed effectively or if resources were available. It is just a matter of competing for them.	Resources are scarce and inadequate.
Specialized Mental Health Professionals and Providers	There is an oversupply of specialized mental health professionals and providers.	There are severe shortages of specialized mental health professionals and providers.
Access to Specialized Mental Health Services	Access to services is fundamentally a problem of removing barriers related to ability to pay, racial or ethnic discrimination, and convenience of location or hours.	Access to services is fundamentally a problem of the lack of availability of services, and solving other access problems will do little until this fundamental problem is addressed.
Mental Health Service Utilization	Specialized mental health services are overused.	Specialized mental health services are underused.
Stigma	Stigma is simply an attitudinal barrier to the appropriate use of mental health services that can be overcome with education.	It is very difficult for a person seeking mental health services not to publicize that fact throughout their entire social network and for that knowledge to be taken into account in all their personal and professional relationships, with very real consequences.
Specialization	Certain kinds of specialization are cost-effective and considered best practices.	Specialization is not practical.
Meeting Client Needs	The obligation is to meet the client's need for specialized mental health services and refer them to other supportive services to meet other needs.	The obligation is to meet the full range of mental health and supportive needs of clients because no other supportive services are available.

FIGURE 1: MENTAL HEALTH PRACTICE: URBAN ASSUMPTIONS AND RURAL REALITIES (CONTINUED)

	URBAN ASSUMPTION	RURAL REALITY
Organizational Capacity of Mental Health Providers	Mental health providers have the staff (e.g., office managers, grant writers, evaluators) and the information systems (e.g., Internet access, electronic billing) that will allow them to participate effectively in state-of-the-art programs and opportunities.	Many rural mental health providers do not have the administrative staff to perform specialized functions (e.g., grant writing, insurance billing); or the telecommunications connections to operate effectively in the modern world of electronic commerce and communication; or the information technology capacity to conduct outcome measurement, sophisticated cost accounting, and so forth.
Professional Ethics	Ethical mental health practice demands clear and distinct boundaries between one's professional and personal life and requires one to avoid entering into a treatment relationship with people with whom you have a previous personal or professional relationship.	Practical realities make it impossible for one to totally separate one's professional and personal life and make it not feasible to totally avoid dual relationships.
Service Delivery Issues and National Public Policy	National public policy issues, such as homelessness, AIDS, intravenous drug use, and so forth, are critical issues for major segments of the population needing specialized mental health services, and specialized programs are needed.	National public policy issues are critical issues for only special segments of the population needing specialized mental health services, and developing specialized programs should be secondary to developing sound, basic mental health services.
Policies on Cost Control	With an excess supply of mental health professionals and providers, costs can be managed or controlled by organizing providers into competing networks.	An inadequate supply of mental health professionals and providers, scarcity of resources, relatively low costs, and providers and informal caregivers distributed across large geographic areas make competition counterproductive and requires cooperation and sharing resources.
The Role of Primary Care	Primary care providers manage a significant number of patients with mild to moderate mental disorders, but refer most patients with serious mental disorder to psychiatrists.	Primary care providers manage patients representing the full range of mental disorder and often provide the only medical oversight for people with serious mental illnesses.
Indigenous Healers and Informal Caregivers	Indigenous healers and informal caregivers are parts of clients' lives that must be dealt with but are not an integral part of service delivery.	Indigenous healers and informal caregivers are essential ingredients in delivering services and meeting the needs of local populations.

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