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Promising Practices in Rural Areas

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FOREWORD

In Denver, Colorado, on July 26, 2002, Secretary of the U.S. Department of Health and Human Services Tommy Thompson spoke of a "new movement for rural America." He shared his vision of a year-long Department-wide effort to find better ways to provide health care services to the 65 million Americans who live in rural areas. This consistently underserved population includes people living in the most remote and isolated areas in the Nation, where delivering services is a logistical and cultural challenge.

While outreach efforts to provide mental health services in rural areas have been undertaken in several States, a review of the literature shows only a limited knowledge base on which new efforts can build. Rural mental health outreach projects need to be identified and evaluated so that other rural communities can benefit from the knowledge and understanding that successful programs possess, to further the goal of disseminating promising practices.

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services, working in partnership with the National Association for Rural Mental Health, conducted a survey that revealed many of the attitudes and practices that can lead to success in rural mental health outreach.

This publication, the result of that survey, is intended as a guide for mental health service organizations working in rural areas across the Nation, to help them meet the needs of those they serve, even in the most remote areas. As SAMHSA works toward its mission to build resilience and facilitate recovery, the needs of rural America will not be forgotten. They too deserve the opportunities for a life in **their** communities. This volume takes a step toward achieving that vision.

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CONTENTS

INTRODUCTION

In rural areas, a chronic disparity exists between the need for mental health services and their availability. Even where services are available, stigma and cultural issues often impede residents of rural areas from receiving the mental health care they need. The importance of outreach services to connect individuals and families to appropriate state-of-the-science mental health services has long been recognized. However, the many challenges of delivering mental health care in rural areas often relegate outreach services to secondary status, particularly in the absence of ongoing funding to support this function.

Despite these obstacles, many rural programs and agencies nonetheless have developed creative approaches to outreach, often in response to specific community needs. Several important events and trends also have heightened interest in how to serve rural residents: the farm crises of the 1980s and 1990s; natural disasters including floods, fires, and hurricanes; school violence; and growing immigrant populations in areas not previously culturally diverse. Often programs have been made possible by funding targeted to specific categorical needs. In such cases, it often falls to the rural leadership to continue providing services after the initial funding period is over.

Rural mental health outreach is generating a great deal of interest and activity in the field, but little current information is available on the subject. To address this issue, the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), joined with the National Association for Rural Mental Health (NARMH) to identify, review, and present successful approaches to mental health outreach in rural areas. Three aims were specified:

A work group including representatives of the consumer community, the NARMH Board of Directors, and the CMHS staff designed and carried out a two-stage survey of rural mental health outreach practices (see Appendix A). The results of the survey indicate that rural mental health outreach currently is being conducted in a wide variety of community service settings. Although these outreach programs vary in staffing levels, services offered, and populations served, there are some compelling similarities among them. These similarities form the basis of the work group's recommendations for rural mental health outreach.

The most important finding is that ***successful outreach programs address the needs of consumers, as they perceive and identify those needs in the context of the communities in which they live.***

It is not just a matter of where outreach services are delivered, but what issues they address and how. Outreach services must work in the context of the local way of life. Because one size doesn't fit all and because most outreach services have not been evaluated, the work group calls its recommended models *promising practices* rather than *best practices*. The results of the survey provide basic principles and practical suggestions for anyone interested in rural mental health outreach.

The **Background** section relates the history of efforts to provide mental health outreach services in rural areas of the United States.

The **Types of Outreach Programs** section defines four categories of outreach and categorizes the 25 programs that responded as illustrations of the four types. Appendix B, Programs Responding to Outreach Surveys, is a list and brief description of the programs.

The section **Doing Outreach** presents the basic assumptions and promising practices for developing, implementing, and maintaining outreach drawn from the survey responses.

The final section, **Policy Recommendations**, is a discussion of lessons learned from experience and an articulation of action items to help provide needed support for rural mental health outreach.

BACKGROUND

The needs and challenges of reaching out to rural residents to connect them with mental health services are issues of long standing. Pursuant to the Community Mental Health Centers Act of 1963, the Federal government funded a number of satellite clinics in remote areas. The clinics were connected to larger community mental health centers and staffed by mental health professionals. They often were staffed only on a part-time basis, yet tended to be costly because of high overhead and low utilization. As a result, the number of satellite clinics has steadily declined. The shift from categorical to block-grant funding for community mental health centers in 1981 and the growth of managed care over the last decade also have contributed to the reduced number of satellite clinics (Geller et al. 1997).

Linking or integrating rural primary care and mental health providers has been a long-standing policy goal backed intermittently by Federal initiatives and funding over the last 30 years (Bird et al. 1998; Lambert et al. 1996). Although this integration remains a cornerstone of rural mental health service delivery, its efficacy as a means of outreach remains limited. Integration usually takes root where there is a tradition or culture of cooperation between primary care and mental health services, and it is difficult to foster in the absence of such a tradition. The heavy caseloads of primary care practitioners and mental health providers in rural areas often prevent them from coordinating care, even when they would like to do so.

Individuals often take on the task of mental health outreach when it is not necessarily a specified part of their role in the community. Circuit riders traveling through a community long have been known for helping persons living in very rural (usually frontier) areas get mental health help and other assistance (Geller et al. 1997). A circuit rider might be a judge, preacher, teacher, or mental health professional who travels through rural areas to work with such community agencies as schools, churches, and hospitals. The United States has a long history of using circuit riders and lay community health workers (also called indigenous paraprofessionals) to provide mental health care (Hollister et al. 1985; Wagenfeld et al. 1994).

How the Survey Was Conducted

The National Association for Rural Mental Health, drawing on its Board and its members, recruited a work group to carry out the project. Board members recruited included a regional director of mental health, an executive director of a community mental health center, the executive director of the Farm Resource Center—an outreach program serving rural communities in four States—and an academically based researcher in rural mental health services. A mental health consumer who has served as a mental health agency program director and is currently the editor of a State consumer newspaper also was invited to join.

Three key issues needed to be addressed to frame the project.

The first is *What is outreach*? Outreach can be defined narrowly or broadly and can be thought of as included in traditional core mental health services or as an ancillary service.

The second is ***What needs to be known about the organizational context in which outreach services are delivered?*** If too little information exists, it is difficult to know which promising practices may be adapted. If too much information exists, services may appear to be limited to their current organizational home.

The third is ***What aspects of the cultural context of outreach services need to be known?*** Cultural sensitivity and competency are considered crucial to reach specific groups defined in terms of ethnicity, age, occupation, or other characteristics. It is important to know how outreach workers are recruited and trained to be culturally competent with respect to the persons they serve and to know whether outreach programs make appropriate cultural accommodations to the community.

The work group reviewed the scant and relatively dated published literature on rural mental health outreach and quickly realized that to identify promising practices would require information from workers and programs currently doing outreach in rural areas. The work group met with four rural outreach workers from the Farm Resource Center. A list of questions distributed to the outreach workers asked how the workers were recruited and trained, which aspects of their job they considered the most important, and which aspects were the most challenging.

The work group meeting provided a good understanding of the fundamental challenges of providing rural mental health outreach, but the group members could see that they needed to know more. They decided to identify and survey known rural outreach programs.

Approximately 200 rural programs were identified from the 2000 list of the Federal Office of Rural Health Policy outreach grantees and from NARMH's membership lists. A brief survey questionnaire, sent by mail, asked the recipients: a) to state whether the agency currently has outreach services, b) to describe these services briefly, and c) to delineate what they would do to enhance outreach if more resources were available. The cover letter explained the purpose of the survey and

provided a working definition of outreach: *providing services to persons not receiving appropriate mental care, including persons receiving no care and persons not receiving as much care as they need.* (The survey and cover letter are found at Appendix A.)

Forty surveys were returned because of incorrect addresses. Forty-one of the remaining 160 were completed and returned. In several cases, two or more surveys referred to the same larger organization and were combined. Five agencies reported that they do not do outreach. In the end, 28 agencies or organizations (from 17 States) currently doing rural outreach completed the initial survey. The questionnaire only solicited information and was not intended to be a representative sample, but the group was very pleased with the rate of return and with the completeness of the information received.

Responses revealed that outreach was being conducted in a wide range of settings and directed to several different populations. A follow-up questionnaire was used to solicit additional information about challenges to providing services; interagency affiliations; how outreach workers are recruited, trained, and utilized; how persons come to access and use services; what cultural issues arise and how they are accommodated; and what each agency believes are the most crucial factors in developing an outreach program. Twenty-four of the 28 agencies responded to the second survey; the responses provide a valuable resource for discussion and recommendations. (The follow-up questionnaire is found at Appendix A.)

The information gained from the questionnaires is not based on a comprehensive survey of all rural outreach projects and cannot be applied universally. In particular, smaller outreach efforts that are not carried out by well-known agencies or organizations, and efforts carried out by grassroots or ad hoc groups, are unlikely to have been surveyed. Therefore, their experiences are not reflected in this discussion. However, the responses did provide an excellent snapshot of rural mental health outreach and the best ways to start a new outreach program.

TYPES OF OUTREACH PROGRAMS

The programs surveyed provide an important snapshot of rural mental health outreach today. The survey revealed that programs tend to vary according to whether outreach is general or specific (tailored to the population) and to what population the effort is directed. Respondents were divided into four categories:

- Tailored outreach to specific populations,
- General outreach to specific populations,
- General outreach to mental health populations, and
- General outreach to general populations.

Tailored outreach to specific populations is best defined as culturally specific outreach to persons experiencing stress and loss due to trauma induced by an economic failure or other catastrophic event. This category is exemplified by two outreach programs developed to serve farmers, their families, and their communities in the wake of the economic trauma attributable to the farm crises of the 1980s and the recent downturn in the farm economy: The Farm Resource Center (FRC) and Sharing Help Awareness United Network (SHAUN).

The *Farm Resource Center* was established in Illinois in 1985 with initial funding from the Rural Crisis Recovery Act, part of the Farm Bill of 1987. The FRC has expanded its services into other States and is currently assisting rural farming communities in Pennsylvania, West Virginia, and North Carolina, as well as in Illinois. It is a key element of the FRC model that Center services are:

- not driven by diagnostic codes,
- provided without cost to the consumer,
- accessible through a confidential toll-free number, and
- provided by culturally sensitive workers trained to know and respect their limitations.

The FRC produced an *Outreach Manual* that draws on the information contained in *Disaster Mental Health: Crisis Counseling Programs for the Rural Community* (SAMHSA/CMHS 1999).

SHAUN provides peer support and professional mental health assistance to Iowa farmers and their families who are dealing with an agriculture-related death or serious disability and related mental health issues. Run by the Wisconsin Office of Rural Health and the Wisconsin Primary Care Association, SHAUN is supported by funding from the Federal Office of Rural Health Policy. Like the FRC, SHAUN recruits outreach workers from the communities it serves and offers training similar to that of the FRC. SHAUN grew out of a larger project called *Sowing the Seeds of Hope* that operates in seven midwestern States.

General outreach to specific populations denotes a program that targets a specific group. The *Healthy Connections* program in Mena, Arkansas, targets at-risk families with a probability of child maltreatment. The program operates in one of the State's poorest and most rural counties. All social services are located in the county seat, in the northern region of the county. Without outreach services, some families would need to travel 100 miles round trip to receive care.

The *Hazard Perry County Community Ministries* program in eastern Kentucky serves adults with serious mental illness throughout a large mountainous service area. The outreach worker's challenge is to find the people living in the "hollow" between the mountains and to get their basic medical and social needs met, sometimes starting with food and shelter. The outreach worker is the crucial link between the consumer and the homeless shelter, psychiatric hospital, and outpatient mental health services.

The *ElderLynk* program serves rural elderly persons in an eight-county area in northeast Missouri. Outreach staff (credentialed in their own areas) locate families and individuals, or are contacted by them, and then link them with appropriate services.

The *North Coast Senior Services* program in Oregon targets persons age 60 and older who are mildly to moderately depressed. As with ElderLynk, advertising and community education are key functions, and the outreach workers attempt to link persons with needed services. The program is run by the Oregon Department of Human Services.

General outreach to mental health populations includes community mental health centers providing outreach to some or all the populations they serve.

Southeast Mental Health Services in La Juanta, Colorado, provides community support services to adults and elderly persons with serious mental illness in six counties (including frontier and rural areas) in southeast Colorado.

Aroostook Mental Health Services serves a very large catchment area in northern Maine. Outreach, considered a core mental health service, is targeted at adults with serious mental illness, children, persons with substance abuse problems, elderly persons in group homes and nursing homes, and persons in emergency or crisis situations. Between 50 percent and 75 percent of persons in these groups are treated through outreach.

Ferry County Community Services in Republic, Washington, provides outreach to persons of all ages who have varying mental health and substance abuse needs. The target group is located in a very rural mountainous county, 100 miles long and 70 miles wide. Outreach workers link persons to other mental health, general health, and support services. Because the

area and many of its citizens are so isolated, the program works hard to understand its population and their needs and to "leave folks alone who want to be left alone."

General outreach to general populations includes community health centers providing mental health services to persons in the catchment area.

The *Butte Community Health Center* in Butte, Montana, a relatively new program, attempts to identify and link persons with appropriate mental health services throughout the service area, located at the top of the Continental Divide. This region has long winters and has the highest unemployment rate in the country. The program is funded by a Federal rural outreach grant and coordinates its services with the Western Montana Mental Health Center.

The *University of New Mexico's Department of Psychiatry* provides training and offers consultation on behavioral health to rural primary care centers in selected areas in New Mexico. Psychiatrists from the medical school provide annual continuing education classes and work with nurses in rural primary care clinics on assessment and diagnosis, medication management, and other mental health care issues.

The *Rural Mental Health Consortium* in Bismarck, North Dakota, funded by a Federal rural health outreach grant, serves eight communities in six counties, typically located up to 80 miles from Bismarck. Some areas have as few as five persons per square mile. The program attempts to work closely with health and human services agencies to provide basic mental health services in these distant and very rural areas.

And on the other side of the world...

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

SO YOU WANT TO DO OUTREACH

When asked *What is outreach?* respondents indicated that outreach is an activity or service that extends beyond the walls of the mental health center or other agency and promotes the availability of mental health services. Programs surveyed varied in the specific outreach services they offered, and their short-term goals for outreach tended to reflect the particular population groups they target (e.g., children, adults with severe mental illness, older persons). Short-term goals sometimes reflected the particular challenges of the geographic area to be served. However, what is most striking about the responses is that there is so much emphasis on the need for, and the challenge of, engaging consumers in their location of choice. There is less concern with the challenges of overcoming long distances, rough terrain, or bad weather. Engaging consumers in places where they feel comfortable is seen as empowering and as resulting in better outcomes.

Find and Engage People

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

Starting or enhancing outreach may be an important step toward getting mental health care to those who need it. However, before deciding whether and how to do outreach, you need to consider some important questions:

- What are your specific reasons for wanting to do outreach?
- What populations do you intend to reach, and with what services?
- What are the goals of the effort?
- What kind of outreach workers do you need and how will you recruit and train them?
- Where will you get the money to support the outreach effort?
- With whom in the community will you need to work, both professionally and financially?

Decide What Your Goals Are

Be specific about your goals and objectives. Thinking concretely at this stage will help you later, when you decide other important issues such as who your outreach workers will be and which community partners you will team up with. Your needs and goals are likely to drive your effort to obtain support for outreach in terms of both human and financial resources.

What are the major problems you want to address? Answering this question is likely to produce a list of specific populations and groups, and the results you want to achieve when you reach out to them.

The *Healthy Connections* program serves one of Arkansas's poorest and most rural counties, targeting at-risk families with a high probability of child maltreatment. These families generally include very young unwed mothers and/or single mothers with two or more children. The program's specific goals are to—

- reduce the rate of child maltreatment,
- reduce the frequency of second and subsequent pregnancies,
- improve parenting skills, and
- reduce corporal punishment.

The focus on at-risk families has led Healthy Connections to be a coalition partner with several government agencies, social service agencies, and educational facilities, as well as with the Arkansas Advocates for Children and Families.

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

Recruit and Train Outreach Workers

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

The FRC and SHAUN both suggest that the kitchen table is the ideal place—the proving ground—for doing outreach. Can you sit around the table and be accepted by the farmer and the rest of the family? Do you truly understand that although clinically the farmer is (or appears to be) depressed, his or her reality is the overdue payments that keep him up at night, or the fear that she's letting down the generations before her who worked this land?

All outreach workers should be self-starters and good time managers. At the same time, they must be flexible and understanding of the time and other constraints faced by the consumers they are trying to reach. An assessment is not likely to be finished in a 50-minute session, but instead may take two or three sessions, with some last-minute cancellations thrown in. Outreach workers must understand their clinical limits. They must be aware that their role is to engage and assess the consumer and to refer the person for help if help is needed. An outreach worker must connect with members of the community, including leaders and other neighbors, and must gain their trust.

How do programs choose and train outreach workers? In part, this depends on the type of agency. Community mental health centers tend to employ a mix of professional and paraprofessional staff to do outreach. Professional staff have a practice credential and receive a brief but fairly intense training in outreach. The completion of continuing education courses in outreach usually is not required. Paraprofessionals also receive brief, intense training and are more likely to receive continuing education than professionals. Primary health care agencies tend to use a mix of professional and paraprofessional staff and provide a modest amount of training to both. Volunteers seldom are used by community mental health centers.

The survey shows that the scope and formality of outreach workers' training vary widely. In general, it appears that more training is needed, but it is difficult to provide because of financial and logistical factors such as availability of trainers, transportation to sessions, and funds to pay for training.

The Farm *Resource Center trains* paraprofessionals more intensely than many community mental health centers, because it relies on them to find and engage consumers and to link them with professional mental health providers.

We have an elaborate training curriculum, including an initial 90-day training program for new hires [and] weekly training every Friday on video so [that] other offices can participate. We have classes that teach diagnosis and doing paperwork correctly. We have classes on medication management and on the psychosocial model of case management that emphasize consumer empowerment.
-Southeast Mental Health Services

There's a very specific training program for case management aides. Regular training programs are conducted either by staff, by outside professionals or sometimes by someone from the pharmaceutical industry. We also have teleconferences provided by the Office of Mental Health. Employees sometimes travel to conferences.
-Lewis County Community Mental Health Center, Lowville, New York

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

We do a lot of in-service trainings ourselves and cover areas that we feel are relevant. We also provide a stipend for staff to go outside for training each year.
-Range Mental Health Center, Virginia, and Minnesota

Staff training is not well organized. We deliver it through in-services and conferences.
-Community Mental Health Center

It is very important to recruit the right type of outreach workers and to monitor and support them. Outreach workers most often are recruited from the communities they will serve, or from similar ones. Professional (credentialed) outreach staff will have had previous education and training. Paraprofessional staff usually are recruited from the occupational or cultural group they will serve. Denominational and lay ministers often make very effective outreach workers because they understand the community and can relate to people on their own terms. Retired teachers and government workers often have a knowledge and understanding of the local community that make them highly effective at outreach. Consumers can share their experiences and their own sense of recovery and can be very effective volunteer, paraprofessional, or professional outreach workers.

Outreach workers should:

- believe in the philosophy and goals of outreach;
- understand the people they want to reach—their circumstances, their needs, and their community;
- be able to meet and work with others on their own terms, in their own surroundings;
- be flexible, be self-starters, and be good time managers; and
- understand the role of the outreach worker, including its limitations and their own.

It is important to recognize when an outreach worker is not working out. Such a person may be a professionally trained case manager who cannot make the transition from office-based practice to going out in the community or may be a paraprofessional who does not understand the role or the need to work closely with professionals. The staff member may need additional training, closer supervision, or reassignment.

Find the Money

Outreach services can be started with demonstration grant money, special legislative authorizations, or an agency's general reimbursement revenues (if outreach is incorporated into ongoing service delivery). Obtaining a demonstration grant or special authorization will get the service started, but it leaves unanswered the question of what to do when the initial funding ends.

One strategy is to use the demonstration period to develop and hone your outreach services so that you can make a compelling case, to your own agency and/or to outside sources, for supporting outreach through reimbursement to the agency's general services budget. Sometimes funding can be leveraged or shared with other organizations. Partnerships with community agencies that have similar goals (e.g., serving children or older persons) may provide an opportunity to share financial support to benefit both groups.