
Meeting the Needs of Rural Adults with Mental Illness and Dual Diagnoses

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Overview

The number of people with mental and brain disorders is a growing public health concern worldwide. Millions of people in the United States have a mental illness or disorder, and the number is increasing. Many people have diagnoses of more than one mental disorder at a time. Almost 45% of people with any mental disorder meet criteria for two or more disorders, with severity strongly related to comorbidity. Although mental disorders are common in the United States, it is those who experience disability due to serious mental illness (SMI) that are in greater need of services. The National Survey on Drug Use and Health (NSDUH) defined SMI as (a) a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders), (b) diagnosable currently or within the past year, (c) of sufficient duration to meet diagnostic criteria specified within the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), and (d) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (Center for Behavioral Health Statistics and Quality, CBHSQ, 2015). In 2014, an estimated 9.8 million (4.2% of all US adults) adults aged 18 or older in the United States had a diagnosis of SMI,

and 43.6% (18.1% of all US adults) had a diagnosis of any mental illness (AMI) (CBHSQ). The NSDUH defined AMI the same as SMI with the exception of resulting in serious functional impairment and limitations of major life activities. In addition, over 8.9 million people have co-occurring disorders – that is, they have both a mental and substance use disorder (Substance Abuse and Mental Health Services Administration, SAMHSA, 2015). According to the 2014 National Survey on Drug Use and Health, of the 43.6 million adults with some form of mental illness, 20.2 million adults (8.4%) had a substance use disorder, of which 7.9 million had co-occurring mental and substance use disorders.

Mental health (MH) and mental illness (MI) exist on a continuum, with no distinct line differentiating health from illness. The manifestation of mental illness varies with age, gender, race/ethnicity, and culture. Mental illness or disorder can range from short-term, situational depression to long-term chronic conditions such as bipolar disorder or schizophrenia (Gustafson, Preston, & Hudson, 2009). The most commonly diagnosed conditions are depression and anxiety disorders, which often are accompanied by substance use or addiction disorders (SAMHSA, 2015). In the United States, depression and major depressive disorders are the leading cause of disability for people aged 15 to 44 years, and almost 43% of persons with severe depressive symptoms reported serious difficulties in work, home, and social activities (Pratt & Brody, 2014). Depression is

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associated with higher rates of chronic disease and increased healthcare utilization (Katon, 2003; Moussavi et al., 2007; Simon, 2001). Furthermore, mental healthcare is the most costly for people (National Council on Behavioral Health, 2015). Wang et al. (2005) found that the rates of treatment for depression often are low and the treatment received is inadequate. In an earlier study, Wang, Demler, and Kessler (2002) found predictors of not receiving minimally adequate treatment which included being a young adult or an African American, residing in the South, being diagnosed as having a psychotic disorder, and being treated in the general medical sector.

Research regarding the prevalence of mental illness in rural versus urban areas is inconclusive. On the one hand, research suggests that mental health disorders are no more prevalent in rural areas than in urban areas; however, they are different (Breslau, Marshall, Pincus, & Brown, 2014; Kiani, Tyrer, Hodgson, Berkin, & Bhaumik, 2013; Wang, 2004). Although Kiani et al. found no differences in the overall prevalence of mental illness by place of residence, they did find that autism spectrum disorder (ASD) was more common in people living in rural areas. On the other hand, research suggests that living in rural areas predisposes residents to risk factors because of lifestyle demands. Fraser et al. (2005) suggest that issues such as high poverty levels and occupational stress in rural areas often require different approaches and knowledge of how these issues and other community-related circumstances come to bare on residents' behavioral health. For example, farmers, farm workers, and their respective families face an array of stressors related to the physical environment, the structure of farming families, and the economic difficulties and uncertainties associated with farming which may be detrimental to their mental health (Fraser et al., 2005). Probst et al. (2006) found the prevalence of depression is slightly but significantly higher in rural residents compared to urban areas and possibly due to differing population characteristics. Yet again, other research suggests that urban living is long known to be a risk factor for psychiatric disorders such as major depression or schizophrenia (Adli, 2011; Schoevers, Beekman,

and Dekker, 2010; Srivastava, 2009). Srivastava concluded that it is the impact of urbanization on people that move from rural areas to urban areas and the loss of social support of the nuclear family that brings the disadvantage of mental health problems. In Schoevers et al.'s study, the authors found significant correlation for prevalence of psychiatric disorders, mood disorders, and anxiety disorders and urban dwellers; however, they found no significant association for substance use disorders. Weich, Twigg, and Lewis (2005) found that rural residents had slightly better mental health than non-rural counterparts. However, the effects of geographic location on the mental health of participants were neither significantly confounded nor modified by socioeconomic status, employment status, or household income.

In this chapter, discussion is on the status of mental health disorders and dual diagnoses in RFT communities and is contextualized from the influence of rural culture on attitudes about mental illness and dual diagnoses, risk factors associated with mental illness and dual diagnoses, and barriers to treatment. The reader is reminded that attitudes toward MI and dual diagnoses vary among individuals, families, ethnicities, cultures, and countries and have numerous influences such as religion, cultural beliefs and practices, and geographical regions. Thus, the information presented in this chapter offers only a sample of various perspectives on MI and dual diagnoses. Throughout this chapter, the terms mental health disorders, mental illness, and behavioral health are used interchangeably.

Learning Objectives

By the end of this chapter, the reader should be able to:

1. Identify barriers to mental healthcare in rural areas.
2. Discuss risk factors for mental health disorders associated with living in rural communities.
3. Understand co-occurrence of mental illness and dual diagnoses.
4. Understand the economic and social costs of mental illness and dual diagnoses.

5. Identify approaches in which interagency collaboration can be implemented to assist persons with mental illness and dual diagnoses in rural areas.

Introduction

According to Kohn, Saxena, Levav, and Saraceno (2004), “mental disorders are not only highly prevalent medical conditions but they are also highly disabling” (p. 858). The effects of mental disorders also result in a high emotional toll on families and society. The treatment gap for mental disorders is universally large. In a review of community-based epidemiology studies using standardized diagnostic instruments and data on the percentage of individuals receiving care for mental disorders, Kohn et al. found the median treatment gap for schizophrenia, including non-affective psychosis, was 32.2%. For other disorders, the gap for depression was 56.3%, dysthymia 56.0%, bipolar disorder 50.2%, panic disorder 55.9%, generalized anxiety disorder 55.9%, and obsessive-compulsive disorder 57.3%. Alcohol abuse and dependence had the widest treatment gap at 78.1%. More recent data suggest that for some disorders, this gap is widening (National Institute of Mental Health, *n.d.*; Reeves et al., 2011). The consequences of lack of treatment include billions of dollars in lost earnings per year, increased hospitalization, earlier death age than others largely due to treatable medical conditions, and suicide (National Alliance of Mental Illness, 2015).

One of the goals of Healthy People 2020 is to “improve mental health through prevention and by ensuring access to appropriate, quality mental health services” (Office of Disease Prevention and Health Promotion, *n.d.*). The present status of mental health services in rural, frontier, and territory (RFT) areas is characterized as inadequate, overlooked, inaccessible, costly, and underfunded (Gustafson et al., 2009; Kessler, et al., 2004; Rural Health Information Hub, 2014; Sawyer, Gale, & Lambert, 2006). The most significant challenge to rural residents receiving care is the lack of mental health professionals

providing mental health services in RFT areas (Mohatt, *n.d.*). Long-standing shortages of MH professional in rural areas have shifted much of the responsibility of care to the primary care sector or rural health clinics (RHCs) (Rural Health Clinic, 2009). In addition, RFT areas have greater numbers of suboptimal healthcare facilities.

The literature shows that RFT areas have unmet needs, numerous barriers to care, and serious problems with access to care in mental health services (Boyd et al., 2008; Costello, Copeland, Cowell, & Keller, 2007; Smalley et al., 2010) and substance abuse (Borders & Booth, 2007; Quinter et al., 2007; Quintero, Lilliott, & Willging, 2007). In light of evidence-based treatment focus, Gray (2011) advocates for a “major focus on the validation of assessments that are used to determine the efficacy of a treatment, testing various treatments within special populations, and examination of the cultural application of treatments” (p. 18). In addition, because of the mental health disparities and lack of mental health professionals in RFT regions, Gray emphasizes the importance of examining the quality of services provided by those trained as behavioral health aides, social workers, psychology technicians, counselors, and marriage and family therapists compared to psychologists (i.e., Ph.D.) and psychiatrists (i.e., M.D.). Finally, because rural residents are more likely to use pharmacology versus psychotherapy for treatment of MH disorders compared to urban residents (Ziller, Anderson, & Coburn, 2010), Gray calls for a closer look at prescription privileges for psychiatrists, use of psychiatric advance practice nurses, and physician assistants to address medication needs. Ziller et al., however, assert that the higher rate of pharmacology use for treatment of MH is not due to the client or patients’ preference, instead because of the likelihood that they will receive treatment of mental illness from primary care physicians.

While healthcare professionals in rural areas are expected to deliver the most appropriate care to individuals with dual diagnosis, a substantial number of them have limited preparation and experience in working with clinical diagnosis issues (Deans & Soar, 2005). Initial levels of training for care providers, as well as subsequent

training, continue to be a barrier to treatment services for residents in RFT communities. Deans and Soar imply that as a result of these limitations, professionals become frustrated, resentful, and powerless in their attempt to understand their client's substance use while simultaneously trying to provide a quality of mental health services.

Barriers to Mental Health Treatment in Rural Areas

Barriers are any processes, devices, obstacles, or circumstances that impede or prevent someone from gaining access to and using services or resources that is of benefit to them. Barriers to service occur for several reasons: (a) the environment (i.e., community acceptance or political will), (b) the clients themselves (i.e., noncompliance, culture), or (c) a lack of service coordination or service fragmentation (organization infrastructure) (Calloway, Fried, Johnsen, & Morrissey, 1999). For persons with mental illness and dual diagnoses in rural areas, these barriers are particularly problematic at the service coordination level because clients need to know both

the “front door” (i.e., knowing where, when, and how to get services) and the “back door” (i.e., continuity of care and follow-up) (Calloway et al.). In rural communities, these barriers to treatment can be further complicated by rural culture attitudes or beliefs (e.g., you don't ask for help). The succeeding barriers are not presented in any particular order of importance.

Availability More than 85% of rural residents live in a MH professional shortage area (Smalley et al., 2010). Gale, Loux, Shaw, and Hartley (2010) conducted a study to examine the changes in the delivery of MH services by RHCs, their operational characteristics, barriers to the development of services, and policy options to encourage more RHCs to deliver MH services. The study revealed that few rural independent providers and provider-based RHCs offer mental health services using doctoral-level psychologists and/or clinical social workers. The majority employed psychologists or clinical social workers on a part-time basis. The models used to provide services included contracted and/or employed clinicians colocated with primary care services. The participants in the study indicated that providing MH services in rural areas was challenging, and the majority reported they were not profitable. Gale et al. identified four barriers that plague RHCs in rural areas: recruitment and retention, reimbursement, administrative, and information and resource (see Table 26.1). In a study of rewards and barriers in rural areas, Allan, Crockett, Ball, Alston, and Whittenbury (2007) found that social workers experienced professional barriers, which had personal implications because they worked alone and because stress related to the seriousness of their client's issues had a significant impact on them. These social workers also felt professionally isolated, even as members of multidisciplinary teams because other team members do not often realize that social workers deal with situations that can have life or death consequences for very vulnerable people. Other barriers expressed included difficulty in accessing training, as well as the travel time and costs, and no financial rewards for the job, especially relative to the stress of the job.

Table 26.1 Barriers to the development of mental health services

Recruitment and retention – Difficulties recruiting mental health professionals due to chronic shortages of clinical social workers, psychologists, psychiatrists, or other clinicians in rural areas, as well as policies established by some payers restricting reimbursement to certain providers. Retention is difficult due to challenges of rural practice including professional isolation and professional boundary issues
Reimbursement – Poor reimbursement rates paid by Medicaid and commercial insurers, increases in patient co-pays and high deductibles
Administrative – Multiple third-party payers, inconsistent reimbursement and credentialing policies, managed care prior authorization requirements used to control utilization costs, and complex state licensure laws. These administrative requirements add costs on clinics and increase staff workload
Information and resource – Limited availability of RHC-specific resources and technical assistance in developing services

Adapted from Gale et al. (2010)

Stigma and Culture “Public (social) stigma is a pervasive barrier that prevents individuals in the U.S. from engaging in mental health care” (Parcesepe & Cabassa, 2013, p. 1). In rural areas, social stigma in combination with a general lack of anonymity in small communities leads frequently to residents not seeking treatment (Gustafson et al., 2009). From a racial/ethnic perspective, Hispanics/Latinos tend to underutilize MH service and prefer to receive treatment from their primary care physicians. People of Asian backgrounds tend to reject MH services and rely more on family for support. African Americans tend to attach more of a stigma to mental illness and receiving services than Whites (Gamm, 2004). The research is limited on American Indians and Alaska Natives’ views of mental illness; however, there is a general worldview that the mind, body, and spirit are connected and MI is an indication of a lack of balance. The degree to which stigma is attached to MI for AIANs is correlated with the level of deculturation from traditional beliefs and to the reculturation process that places them into the western health belief system (Grandbois, 2005). AIANs appear to use alternative therapies (e.g., spiritual healer, medicine man). The diversity of AIAN tribes does not allow for generalization of information about their views on MI. (See Chap. 3 for discussion on AIANs.)

In addition to cultural norms that regulate attitudes toward mental illness, rural residents must contend also with the traditional or conventional cultural belief systems that characterized rural communities (Letvak, 2002; Slama, 2004), as well as religious beliefs. Some rural residents may rely more on religion to cope with stress or believe that faith and prayer are sufficient forms of intervention. Rural residents may be concerned about seeking care of mental illness and substance abuse problems because of privacy concerns. Often, in RFT communities, the client seeking treatment may know the service providers and other workers within the treatment facility. In addition, clients may be concerned about other clients or patients noticing them utilizing mental health services and/or substance abuse treatment services. These concerns are further

compounded by dual relationships, which may make people in rural areas reluctant to consult a mental health professional. (See Chap. 3 on dual relationships.) To help reduce these concerns, the Rural Health Information (RHI) Hub (2014) recommends collocation or integration of behavioral health services with primary care.

Fear and Distrust Fear of seeking mental health treatment is a barrier that is closely associated with culture, stigma, and shame. Overwhelmingly, RFT residents have a mistrust of mental health professionals (Russell, 2010; Sawyer et al., 2006). People find it difficult to reveal personal details to a counselor or doctor and have concern about “telling a stranger” about their problems (Susman, 2015). Racial/ethnic minorities’ distrust may rest more in historical traumas and other economic and sociopolitical injustices. People recognize the negative stigma and discrimination associated with having a mental illness and do not want to be labeled as such. Many people fear that a label of mental illness could negatively impact their employment or career, education, or other life goals (Susman). Rural areas often have fewer and less diverse employment opportunities, and people fear that if knowledge of their mental illness were to become known, they may lose their job or not be considered for another job.

Costs Costs of care are another barrier to treatment in RFT communities. Although the Affordable Care Act (ACA) has increased access to healthcare for people, many rural residents cannot afford to pay for treatment or lack health insurance coverage. Gustafson et al. (2009) states that cost is perhaps the most pervasive barrier limiting access to mental healthcare services in rural America. Rural residents that are uninsured are more likely to delay or forgo treatment because of cost, especially Black, Hispanic, and American Indian rural adults. Rural populations have a larger proportion of low-income residents who could benefit from the ACA; however, almost two-third of uninsured rural residents live in a state, which has not expanded Medicaid. In addition, Hispanic/Latino adults in rural areas are

most likely to be uninsured. Rural poor White residents are more likely to have insurance than poor rural racial/ethnic minority or other marginalized groups (Bennett, Olatosi, & Probst, 2008).

Other cost-related barriers include financing and reimbursement. According to Sawyer et al. (2006), these barriers range from uncertainty of public funding streams to funding systems that are complex and fragmented leading to increased costs for providers. More recently, the impact of payment assistance for MH services has been found to be a beneficial option for rural residents seeking mental health services in mental health treatment facilities. Payment assistance is offered in the form of no charge or a sliding-fee scale. Both of these options serve as a safety net for those individuals who need but cannot afford to pay for these services (Smith, Kuramoto-Crawford & Lynch, 2015). Although estimates of the number of MH facilities nationwide that provide MH services without charge or with some financial aid are not available, Smith et al. conducted a study to determine the availability of payment assistance for MH services in mental health facilities in the United States. They found that almost 9% of MH treatment facilities offered services with a sliding-fee scale, another 15.5% offered services at no charge only, and 42.7% offered both types of payment assistance. Approximately 20% offered neither type of payment assistance.

The availability of payment assistance also differed by type of treatment facility. Payment for assistance was offered in 88% of outpatient mental health center, 86.2% of multisetting mental health facilities, 76.6% of psychiatric hospitals, and 71.4% of general hospitals with separate psychiatric units. Among residential treatment centers (RTCs), 69% offered payment assistance for adults, and only 38% offered such assistance for children. Multisetting facilities provide outpatient and residential MH services and are not classified as a psychiatric or general hospital with a separate psychiatric unit or as RTCs (SAMHSA, 2014). Of those facilities that offered payment assistance, the majority (83–89%) provided either cognitive or behavioral therapy, individual psychotherapy, group therapy, and psychotropic

medication therapy, and over half (56.7%) offered integrated dual disorders treatment (Smith et al.).

In the Smith et al. (2015) study, the availability of pay assistance varied by type of care facilities, facility operation, and whether the facility was located in an urban or rural area. Compared to urban facilities, rural areas had higher availability of a sliding-fee scale or free care. The higher rate of usage might be explained by Ziller et al. (2010) who suggest that the greater availability of payment assistance in rural settings coincides with higher rates of uninsured and underinsured persons in rural areas than in urban ones. Overall, children were least likely to be offered payment assistance. Thus, Smith et al. raised concern about the accessibility of service for children in need of residential care, especially since they have no way of paying for treatment. As a result, one can speculate that children who do not receive MH services will more than likely become adults with MI who do not receive services.

Budget Cuts Closely aligned with cost of services is budget cuts in mental health service funding by the states. In a review of states' budgets between 2009 and 2011, a report by Honberg, Diehl, Kimball, Gruttadaro, and Fitzpatrick (2011) for the National Alliance on Mental Illness (NAMI) found states cumulatively cut more than \$1.8 billion from their budgets for services for children and adults living with mental illness. Although states differ in the way they report and break down of their budget information, the magnitude of cuts is staggering. Because of the magnitude of these cuts, Honberg et al. evaluated the cuts in two ways. First, they looked at the cuts in general funds (actual dollar amounts). The ten states that made the most cuts in general funds ranged from \$587.4 million to \$44.2 million. For example, in ascending order, the dollar amounts were California cut \$587.4 million, Kentucky \$193.7 million, New York \$132 million, and Illinois \$113.7 million. Second, Honberg et al. examined budgets to determine which states made the largest cuts by percentage of their overall state mental health general fund

Table 26.2 Principles of ACT

<i>Primary provider of services.</i> ACT specialists are highly trained and well-versed in all areas of treatment including substance abuse, mental health, and vocational skills. Their 1:10 ratio of professionals to patients ensures that persons receiving care get the most attentive treatment possible
<i>Out-of-office treatment.</i> Treatment occurs in the individual's home or a local community setting, such as a park or library
<i>Individualized treatment.</i> Each person is unique in his or her illness and/or addiction. ACT recognizes this and tailors treatment to each case
<i>Long-term services.</i> A person seeking treatment can do so anytime as staff members are available and understand that recovery is a lifelong commitment
<i>Vocational expectations.</i> Staff qualified in teaching vocational and life skills help a patient with job placement and employment opportunities
<i>Psychoeducational services.</i> Clients are taught about their illness and together with the provider work on ways to cope with the difficulties of severe mental disorders
<i>Family support.</i> Families are often impacted in ways we do not recognize. Providers educate families on the illness and offer support services to make dealing with it a little easier
<i>Community integration.</i> Because many patients with comorbidity are socially isolated or have trouble communicating, ACT professionals work with the individual on society integration to make them feel more comfortable in the community.

Adapted from <http://www.dualdiagnosis.org>

budget. Ten states made cuts ranging from 47% to 15%. Based on the second approach to viewing the budget cuts, three states from the first approach had made less than 15% of cuts, and three additional states were added. For example, in ascending order, the percentages of cuts were Kentucky cut 47.5%, South Carolina 22.7%, and Arizona 22.7% (Honberg et al.).

Given the amount of cuts in funding to treat MI, the question that is raised is, what do cuts of this magnitude mean in human terms? These consequences translate into frequent visits to emergency rooms, hospitalizations, homelessness, entanglement with juvenile and criminal justice systems, the loss of critical developmental years, premature deaths and suicides, and further diminished access to needed services (Honberg et al., 2011). In addition, the elimination or downsize of

specific services are those that are most essential to helping persons who are living with serious mental illness to avoid crises and move forward. These include acute (emergency) and long-term hospital treatment; crisis intervention teams and crisis stabilization programs; targeted, intensive case management services; Assertive Community Treatment (ACT) programs (provides all-around care that focuses on more than the illness and addiction) (also known as assertive outreach, mobile treatment teams, continuous treatment teams, program of assertive community treatment, or other state-specific names) (see Table 26.2); supportive housing; targeted case management and clinical services for children and adolescents; and access to psychiatric medication (Honberg et al.). In rural areas, these cuts in MH funding come on top of already inadequate funding, with a largely uninsured and underinsured population, and at a time when the demand for MH services is increasing. These circumstances combine to create a national crisis. In the wake of budget cuts, a potential support for MH facilities in RFT communities is to seek grant funds from the US Department of Agriculture (USDA). In 2013, the USDA announced an investment goal to increase access to MH care in rural areas. The funds, which are provided through the Community Facilities Program authorized by the Consolidated Farm and Rural Development Act, can be used for construction expansion or equipping rural MH facilities. These funds can also help to expand and improve the services already offered by MH facilities in RFT communities (USDA, 2013).

Transportation, Isolation, and Inclement Weather Three circumstances converge to magnify barriers to mental health services in rural areas: isolation, inclement weather (see Chap. 33), and a lack of transportation. Rural residents are more likely to have to travel long distances to access healthcare, substance abuse treatment, and mental health services, particularly specialist services. In many cases, the roads and terrain are difficult and are made hazardous by inclement weather. Long distances to treatment, a lack of public transportation, and/or a lack of personal

transportation all converge to make access to treatment challenging. (See Chap. 3 for information on transportation and accessibility.) Lack of transportation also creates potentially unsafe situations for individuals who travel to urban areas for MH services, such as when they are discharged from services in other communities with no method of returning home. In addition, travel to rural areas by MH service providers is a cost that community MH agencies have to absorb because travel costs are not considered in funding formulas or caseload benchmarks. As a result, community MH agencies must allocate a significant part of their resources (i.e., money and staff time) to transporting clients and providing outreach services (Canadian Mental Health Association, 2009).

Structural and Organizational Issues Often, a client or patient in the healthcare and mental health systems has to deal with multiple care providers across numerous specialty areas. During the process of healthcare services, there is insufficient communication among primary care providers and community mental health centers. The sharing of client or patient information is restricted by HIPAA (Health Insurance Portability and Accountability Act) or by incompatible software or hardware and inadequate infrastructure for telehealth connections. Frequently, there is lack of coordination among federal agencies, especially Health Rural Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA). In an era when external funding (i.e., grant funding) is necessary for organizations to continue or enhance services, many rural providers lack the organizational capacity or expertise. Sometimes, the barrier is that government agencies use urban criteria for contracts or grants (i.e., comprehensive rehabilitation programs). Furthermore, “resources have been concentrated in urban areas of the United States, and the limited availability, accessibility and acceptability of rural mental health and behavioral health services have created serious consequences for individuals, families, and state mental health authorities” (Sawyer et al., 2006, p. 8).

Some of these barriers are more problematic for mental health or substance use treatment, and others apply equally to medical care (National Alliance on Mental Health, 2015). The challenge that remains is to find feasible and enforceable strategies to remove barriers in RFT communities. The 2003 Presidential Commission report described the mental health system as “a ‘patchwork relic’ of disjointed state and federal agencies that frequently stepped in the way of people who were seeking care instead of helping them” (Russell, 2010, p. 30). The report called for the system to be more streamline, which focused strongly on early diagnosis and treatment in patients’ own communities, to have high expectations of recovery, and to use methods for helping people with mental illnesses find work and housing. The report, however, did not recommend increased funding for mental health, rather for a more coordinated and efficient use of the money already available (Russell).

Risk Factors for Mental Illness in Rural Areas

Risk factors consist of socioeconomic conditions that can predispose or increase someone’s vulnerability, thereby decreasing their ability to respond effectively to risks. In addition to the barriers previously discussed, rural residents are vulnerable because of less socioeconomic and social resources, less education, higher poverty, higher unemployment rates, inferior housing, higher rates of chronic disease, and less use of preventive health screening. Moore et al. (2005) suggest that rural residents, especially children, are not protected from biological and environmental factors that can cause MH problems. This suggests that even at a young age, residents of RFT areas are at risk for MI, and if left untreated, these disorders persist. Although lifestyle factors and behaviors are more important predictors of MI than remoteness per se, health-affecting behaviors are embedded in relationships between individuals and organizations, communities, families, and friends (Smith, Humphreys, & Wilson, 2008).

Geographic and Isolation-Based Factors Generally, “geographic location and rural environments directly influence some aspects of the health status of rural populations” and “indirectly compound problems originating from more fundamental structural or social causes” (Smith et al., 2008, p. 57). The physical boundaries and geographic isolation impose a barrier to mental health accessing services and suicide prevention in rural areas. Lack of access to preventive or emergency care because of distance and a shortage of providers in mental health are also critical characteristics of suicide occurring in rural geographic locations (Hirsch & Cukrowicz, 2014). The more isolated and greater distance from urban areas, the more health deteriorates, including mental and physical health, higher rates of disability, lower life expectancy than the national average, and increased exposure to violence, poisoning, suicide, and accidental death (Haggarty, Ryan-Nicholls, & Java, 2010).

Protective Factors Protective factors are usually positive attributes or strengths that increase resiliency and enhance a group’s survival strategies (see Chap. 7 for discussion on rural resilience). For many rural residents, the same protective factors (e.g., cultural identity, traditional health practices, family, rugged individualism) that function as strengths can simultaneously serve as risk factors and/or barriers to help seeking for MI disorders. For example, the belief and practice of being independent and solving one’s problems without assistance from others, especially mental health professionals, often result in individuals not seeking help. Family members can hinder the client from seeking treatment if they also share these values. In addition, family members can interfere with the client’s treatment because they fear the client may get better and no longer qualify for disability payments, which could change the financial situation of the family. This concern is especially so if the client’s disability payment is the primary source of income for the family.

In contrast, Goodwin and Taha (2014) examined the association between being raised in a rural setting and physical and mental health among adults in the United States and found

there are global health benefits of being raised in a rural setting (see Research Box 26.1). Goodwin and Taha asked a question to all participants about what sort of environment they were raised in for the majority of their childhood. However, what is not clear in their study is whether they asked if the participants lived the majority of their adult life in a rural setting. This raises the question of whether the results would have been different if a distinction was made between being raised (as a child) in a rural setting and living (as an adult) in a rural versus an urban setting. Other studies suggested that being born and raised in the same rural community is protective against developing mental disorders, whereas migrating between rural to an urban area or even migrating between rural environments may be a risk factor for developing psychological disorders (Maggi et al., 2010; Ostry, Maggi, Hershler, Chen, & Hertzman, 2010). Remaining in the same rural area provides adolescents and adults with an important sense of security and control that buffers against MI. Hirsch and Cukrowicz (2014) concur that capitalizing on protective characteristics of rural communities may be an important strategy to build upon.

Research Box 26.1: See Goodwin and Taha (2014)

Objective: To examine the association between being raised in a rural setting and physical and mental health among adults in the United States.

Method: Data were drawn from the National Comorbidity Survey ($n = 8098$), a household probability sample representative of adults aged 15–54 years in the United States. Multiple logistic regression analyses were used to determine the association between being raised in a rural area and the likelihood of mental disorders, physical disorders, suicide behavior, and parental mental health. Odds ratio (OR) with 95% confidence intervals was calculated, adjusting for differences in demographic characteristics.

Results: The sociodemographic characteristics of adults who were raised in a rural setting had a lower income, less formal education, more likely to be married, or formerly married, between the ages of 35 and 54 years old, male, and Caucasian compared to those who were not raised in a rural setting. Being raised in a rural setting was associated with decreased odds of ulcer. Mental disorders (any lifetime), any anxiety disorders, and any substance use disorders were significantly less likely among adults who were raised in a rural setting. Maternal psychopathology and exposure to trauma were significantly lower among those raised in a rural setting, compared with those who were not. These relations were not explained by sociodemographic differences.

Conclusion: These data provide preliminary evidence that being raised in a rural environment lowers the risk of mental and physical health problems in adulthood. Being raised in a rural community also appears to be associated with significantly lower likelihood of exposure to trauma and maternal psychopathology. Future studies can identify potential protective factors and mechanisms underlying these pathways are needed next.

Questions:

1. How might this data look differently if it were disaggregated by geographical region?
2. Given the limited diversity of the sample, what are the implications for racial/ethnic minority populations?
3. What other variable would you like to include in a study of this type?

health information such as following instructions from healthcare providers, managing chronic illness, or taking medication properly (DeWalt, Berkman, Sheridan, Lohr, & Pignone, 2004; Healthy People, 2010; RHI, 2016). Low health literacy is another risk factor for poor health outcomes in RFT communities. People with low health literacy have higher healthcare usage (i.e., more preventable hospital visits, greater use of the emergency room), are at greater risk of misunderstanding treatment recommendations, have problems in accurately taking prescription medications, and die earlier (Berkman, Sherdian, Donahue, Halpern, & Crotty, 2011; Vernon, Trujillo, Rosenbaum, & DeBuono, 2007). Those with low health literacy experience shame that may manifest as being intimidated of filling out forms, difficulty reading signs and locating places, and frequent medication errors. Unfortunately, medical staff and service providers may reinforce the shame experienced by individuals. Rural residents are at risk for low health literacy because they have lower educational levels as compared to residents in urban areas. For people in poverty and those with limited English proficiency, low health literacy is particularly problematic. Other common reasons for low health literacy include poorly developed materials and confusing instructions, learning disabilities, and a lack of frame of reference. People with chronic MI and/or physical health conditions are among those most likely to have low health literacy (Krishan, von Esenwein, & Druss, 2012). Schillinger (2011) asserts that vulnerable populations are at risk for health disparities not only because of their own literacy skills but also failure of health professionals to successfully communicate with patients who have limited health literacy regarding medication instruction, patient history, discussing symptoms and barriers to care in the absence of a physician eliciting it, and patient understanding of explanations and results and whether they ask questions. See Discussion Box 26.1 for an example of a prescription label that all patients are given regardless of their literacy level.

Low Health Literacy Health literacy is the degree to which patients understand basic

Discussion Box 26.1 Health Literacy



Professional Pharmacy

000 Main Street, Anywhere, USA
00000 (800) 000-0000

Caution: Federal law prohibits transfer of this drug to any person other than the patient for whom prescribed.

RX# 000-000-000 Dr. John Doe
Smith, John Date March 15, 2016

Take one tablet orally daily or every 6 to 8 hours as needed for symptoms

24 FazaClo Tab 10/500mg

No refills Clozapine Use before
March 15, 2019

Do not take this drug if you become pregnant.

Do not drink alcoholic beverages when taking this medication.

May cause drowsiness or dizziness.

Discussion Questions

Presented above is an example of prescription label on a bottle of medication. Imagine a person with a low literacy level having to read this label.

1. Can you identify what each line on this label means?
2. What other information should come with this prescription?
3. What are some problems encountered by a person with a low literacy level?

Race/Ethnicity Some racial/ethnic minority groups are at increased risk for mental illness or dual diagnoses not because of their racial or ethnic identity but because of economic and social circumstances that put them at risk. In addition, the location of MH services might add to the potential for risk. For example, the availability of MH services is limited by the rural, isolated location of many AIAN communities. In addition, for AIANs, most clinics and hospitals for the Indian Health Service are located on reservations, yet the majority of American Indians no longer reside on reservations (American Psychological Association, 2010). AIANs have a historical precedent of alcohol abuse since the introduction of alcohol by frontiersmen and explores early in colonial history. “High rates of alcohol abuse in Indian Country are coupled with similarly high rates drug abuse” (p. 8). The rate of methamphetamine use in Indian country is over three times the rate of the general population (Iritani, Dion Hallfors, & Bauer, 2007). In fact, Jefferson Keel of the National Congress of American Indians believes “the destruction caused by methamphetamine threatens to dwarf the problems we have seen caused by alcohol” (cited in Indian Health Service, 2011, p. 9).

What constitutes mental illness or mental health is subject to many different interpretations and varies across racial/ethnic groups and cultures. In many racial/ethnic minority populations, MI is not seen as something that is wrong with the individual but rather more of society’s effect on the individual. As such, MI is not viewed as pathological. Moreover, an individual is accepted within the community, and others recognized him or her as being a little different but not perceived as a danger to anyone. Cultural perceptions or misperceptions about MI can be as much a risk factor as other social risks (Dixon & Vaz, 2005).

Poverty The link between poverty and MI is well known (McGovern, 2014). Once an individual becomes incapacitated, his or her socioeconomic status is likely to decline further (Tiffin, Pearce, & Parker, 2005). In Australia, the United

Kingdom, and the United States, four in ten people with severe mental disorder live in households with incomes below the low-income threshold, and the proportion is almost as high in other countries (Organization for Economic Co-operation and Development, OECD, 2012). Low educational level is linked to poverty. Ethnic minorities, older patients, and less-educated patients are more likely to have treatment disparities and to receive lower-quality care than other patients (Ahn et al., 2008). Each of these groups is overrepresented in poverty status, and rural residents have higher rates of poverty compared to their urban counterparts. Rates of hospitalization for psychiatric conditions are 44% higher for people in poor communities than in nonpoor ones and twice as high for poor people with schizophrenia (Healthcare Cost and Utilization Project, HCUP, 2008). Amoran, Lawoyin, and Oni (2005) found unemployment and living conditions below average, physical health, and large family size were associated with increased risk for psychiatric morbidity for rural populations.

Lack of Quality of Care The majority of primary care physicians express confidence in their ability to manage mental health problems; however, they do not always provide evidence-based care. (See Chap. 38 for discussion on evidence-based practices.) Primary care providers are often the first and only resource for RFT residents needing mental healthcare. Training on MH issues is not easily accessible for primary care providers in rural areas (McFaul, Mohatt, Ciarlo, & Westfall, 2009). As previously stated, primary care physicians in rural areas tend to overprescribe or, at least, rely heavily on medications (e.g., antidepressants) as the treatment of choice for mental disorders. Often, the dosage is not appropriate and the requisite follow-up visits are not always scheduled nor is psychotherapy included or always available (Russell, 2010). Russell stressed that it is not sufficient to simply improve the level of diagnosis of mental disorders; more must be done to ensure that patients receive beneficial,

evidence-based therapy. While there is evidence showing that psychotherapy (e.g., cognitive behavioral therapy) is one of the primary treatment modalities for mental disorders, there are no training, licensure, or certification requirements obligating providers to have competence in such therapies. Also, there is usually no systematic way for clients/patients or providers to identify practitioners who deliver these treatments (Patel, Butler, & Wells, 2006). Quality of care is hampered further when service systems and practitioners are not up-to-date with current science (Braun, n.d.).

In this section, I have discussed risk factors for MI in rural, frontier, and territory communities. These are risk factors in general and not necessarily generalized to all rural residents. Rural areas are not homogeneous. Other characteristics, such as those previously mentioned, and age, level of adherence to traditional or indigenous practices, regionally specific characteristics, and other cultural and regional attributes are intervening and moderating factors for risk.

Dual Diagnosis

Comorbidities are related to multiple issues including substance use and psychiatric disorders, multiple psychiatric disorders, and psychiatric or substance abuse disorders and a health-related diagnosis (Gray, 2011). (See Chap. 28 for discussion on substance abuse.) A large number of people with MI have comorbid substance use or physical health conditions (Greenberg, 2012). People with SMI have a higher prevalence of diabetes and heart disease (Miller, Paschall, & Svendsen, 2006), and many medications used to treat SMI also increase risk of diabetes (American Diabetes Association et al., 2004). Some people who are SMI take drugs or alcohol to alleviate their symptoms (self-medicating). Frequently, these individuals are undiagnosed as having a mental disorder. Other individuals with a diagnosis may stop taking their medications in order to use a substitute

substance. Yet, others who are chronic substance abusers may trigger a mental disorder, known as a drug-induced disorder. Whatever the circumstance, individuals who are dually diagnosed rarely receive simultaneous treatment for their mental disorder and their substance abuse (Russell, 2010).

Patients or clients with dual diagnoses have therapeutic challenges presented by comorbid psychiatric and substance abuse disorders. The effect of excessive substance use on an individual's mental well-being can present as a diagnostic challenge as each condition may mask symptoms of the other (Deans & Soar, 2005). Often, dual-diagnosed clients are difficult to work with because as a group they tend to seek services for substance abuse treatment only as a result of personal, family, or legal problems. In addition, they frequently have fragile support systems because behaviors associated with their diagnoses have depleted these systems. Another reason dual-diagnosed clients present a challenge in treatment is because they have "interchangeable denial" that involves the utilization of one problem to defend the other (Doweiko, 2015, p. 353). For example, a client with bipolar disorder will want to talk about his or her substance use disorder when the mental health professional is focused on the MI. On the other side, if the rehabilitation professional wants to focus on the substance use disorder, the client will want to talk about his or her bipolar.

The difficulty in working with dually diagnosed client is not necessarily the fault of the client. There is a "professional blindness" in which healthcare professionals view dual-diagnosed clients as being primarily substance-abusing patients who require addiction treatment (Doweiko, 2015, p. 354). Conversely, the rehabilitation professional views the same client as being a psychiatric patient. The result is that the client goes back-and-forth between the two programs (Doweiko). According to the Parliament of Australia (2006), the erosion of the skill base among psychiatrists and nurses is in part a consequence of the specialization of service delivery

into separate and distinct silos, for example, MH against substance disorder services. In addition, clinicians in rural areas working with dual-diagnosed patients experience frustration, resentment, and powerlessness in their attempt to understand their clients' drug misuse and simultaneously trying to provide MH services (Deans & Soar, 2005). In rural areas, the client potentially will not receive treatment for neither of his or her diagnoses because of barriers previously discussed.

Social and Economic Costs of Mental Illness and Dual Diagnoses

The economic costs of MI have never been easy to pinpoint but can be estimated much the way we estimate other healthcare costs (Insel, 2008). However, much of the economic burden of MI is not the cost of care but loss of income due to unemployment, expenses for social supports, and a range of indirect cost due to a chronic disability that begins early in life (National Institute of Health, 2011). Mental illness and/or substance abuse have direct and indirect costs. The direct costs refer to treatment expenses and include increased medical expenditure and costs for long-term care. Poor mental health drives up the costs of treating other health conditions (Insel, 2008; Wu et al., 2005). More than half of all mental health expenditures are paid for by the public sector (Medicaid, Medicare, state, and local government) and individuals with MI or SMI account for approximately 32% of recipients that qualified for Supplemental Security Disability Insurance (SSDI) as of 2013 (National Alliance on Mental Health, n.d.). Likewise, in England, mental illness represents the single largest cause of disability and the most costly for the government in terms of treatment, welfare benefits, and lost productivity at work (McCrone et al., 2008). Indirect costs refer to non-health costs. From a broader social perspective, people with SMI or untreated MI and/or dual diagnoses experience higher rates of unemployment, are poorer than the general pop-

ulation, and have more absences from work, reduced productivity at work, high worker compensation claims, low levels of job satisfaction, high rates of occupational injury, and higher rates of domestic violence. These factors lead to significant indirect economic costs (Insel; OECD, 2014).

People with SMI have a life expectancy on average of 25 years less than people without SMI (National Association of State Mental Health Program Directors, NASMHPD, 2006). An overwhelming majority of people who committed suicide had a SMI (Ruter & Davis, 2008), and those with dual diagnoses have greater risk of suicide attempts than non-dual diagnoses (Gimelfarb & Natan, 2009). People with dual diagnoses experience the worst social and health outcomes including homelessness, forensic involvement (criminal justice system), and more exposure to violence and exploitation both as victim and perpetrator (Honberg et al., 2011; Parliament of Australia, 2006). In general, people with dual diagnoses have a higher level of need than other cohorts with mental illness and a poorer prognosis compared to those with either a mental or substance abuse disorder alone (Parliament of Australia).

The social interference of mental illness and dual diagnoses will vary from person to person depending on severity, treatment compliance, and supports. In general, MI can interfere with a person's ability to think clearly, manage emotions, make decisions, and relate to others. People can experience multiple symptoms, both emotional and physical. While these symptoms and experiences are not unique to people in RFT areas, availability and access to resources to which to respond can alter the outcomes for rural residents.

Rethinking Approaches to Service Delivery in Rural Areas

Russell (2010) described the US mental health service delivery system as "pluralistic and minimally coordinated, with a persistent division between public and private sector providers, ..." which "makes it difficult to translate methods for

estimating workforce adequacy from health to mental health” (p. 31). If disability due to mental disorders and dual diagnoses in rural areas is to be reduced, the treatment gap in mental healthcare must be reduced. “The treatment gap refers to the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder” (Kohn et al., 2004, p. 859). Thus, the solution to addressing the healthcare needs of persons with SMI and substance use disorders and behavioral health needs is straightforward: (a) close the gap between those who require treatment and do not receive it; (b) better integrate medical and behavioral healthcare, as well as substance use and mental healthcare; and (c) expand the use of evidence-based practices to coordinate care, treat behavioral health disorders, and treat chronic mental conditions (National Council for Behavioral Health, 2015). According to Gale and Lambert (2006), there is a renewed interest in the integration of MH and primary care services, particularly in rural areas. This large interest among rural primary care providers in learning about MH issues follows the national trend for greater integration of primary and MH care and suggests that they are aware of the impact of MH on their patients’ physical health (McFaul et al., 2009).

Integrated Health and Mental Health Services Behavioral health services are divided into three focus areas: mental health, substance abuse, and domestic violence (Eilrich, St. Clair, & Doekse, 2005). Eilrich et al. assert that these divisions create barriers to care because frequently the proper treatment involves more than one of these areas. In addition, comorbidity disorders are recognized beyond only behavioral health because individuals with serious or chronic physical health problems often have comorbid behavioral problems (Kessler, Chiu, Demler, & Walters, 2005). For many people, their mental disorder is a chronic condition; thus, mental illness needs to be included alongside other chronic conditions when protocols and strategies are established to better address and manage them. Addressing mental illness as comorbidity with other chronic conditions is an impor-

tant way to treat patients, improve quality of life, and reduce healthcare costs (National Council for Behavioral Health, nd; Russell, 2010). Likewise, the National Rural Health Association (2013) asserts that integrating primary care and behavioral health increases access to behavioral healthcare for rural residents, and when the two services are provided in the same healthcare setting, people are more likely to take advantage of the behavioral health services. Accessing mental health services through rural primary care provides a type of privacy for the client/patient. When an individual is seen entering the physician’s office, there is no incidental reveal that he or she is accessing MH services. In addition, stigma is reduced for the client as well.

Unuter and Druss (2013) discuss the collaborative care model, which represents an evidence-based approach to physical-behavioral health integration. The model is an example of strategies to improve the integration of behavioral and physical healthcare and an innovative payment model to cover the costs of care. The model is implemented within a primary care-based Medicaid health home model and among other settings. Collaborative care includes (a) care coordination that can be care management, (b) regular/proactive monitoring and treatment to target using validated clinical rating scales, and (c) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement (Unuter & Druss). Ouimette et al. (2007) stressed that understanding how to implement evidence-based practices is critical to improving care of dual diagnosis patients because when best practices are not consistently implemented and when administrative barriers exist, provision of more effective care is hindered.

Efforts to integrate service delivery should be approached in two ways: (a) short-term strategies and (b) long-term methods. In the short term, service providers need to identify strategies to provide immediate response to RFT residents who are experiencing MI while simultaneously expanding outreach and prevention services. Long-term methods first must change the culture

of medicine and affiliated healthcare professions, the ways these services are delivered, and funding and reimbursement guidelines. Both short-term and long-term approaches will require those who deliver MH services and medical care to initiate and sustain change (Russell, 2010). Yet, after the passage of the Mental Health Parity and Addiction Equity Act of 2008, there is little evidence that the system of mental healthcare has been transformed or that the burden of MI has been reduced (Greenberg, 2012).

Public Education Collaborative Moore et al. (2005) recommended the establishment of a public education collaborative that can inform rural residents of the importance of early intervention for MI. As author of this chapter, I offer the following recommendations for consideration. One of the major barriers to informing rural residents about MH screening and early intervention is the inability to disseminate information in an effective and efficient way across sparsely populated regions. In part, this is due to the digital divide between rural and urban areas. One solution is that libraries can facilitate online access to health information among vulnerable and underserved populations (Kreps, 2005). Another possibility is to use Cooperative Extension offices. Each county in states with an agricultural base has an extension office. A third strategy is to have medical and dental outreach programs distribute information on MH well-being as part of their outreach program. Not only is this a way to disseminate information, but doing so as part of healthcare services is a way to not call attention to MH information as something separate from healthcare, thus reducing the stigma.

Telemental Health Telemental health counseling (also known as telebehavioral health or telepsychiatry) is another approach that has been implemented in rural areas. Telemental health employs the use of telecommunication technology to deliver behavioral or mental health services. Delivery of services is typically divided into two categories: synchronous and asynchronous. Synchronous is live, real-time interactive two-way communication (i.e., telephone, video teleconfer-

encing). Asynchronous is not in real time and usually involves the transmission of reports or information to a distant site to review at a later time. Telemental health offers the advantages of increasing availability of services to clients in RFT areas, decreasing costs, and saving or maximizing time and effort. Because mental healthcare often requires a multidisciplinary team approach to best serve the client, telemental health allows for provider-to-provider consultation. Furthermore, this approach can be incorporated easily into the method of integrating primary care and MH care. It is generally agreed that health information technologies can help providers manage the complex chronic care needs of rural residents that have scarce access to medical specialties. However, connectivity issues in most rural areas remain a problem. Connectivity refers not only to the availability of the Internet and broadband services but also disruptions in service, for example, because of hunters shooting down power lines (Hook, Grant, & Samarth, 2010).

Telemental health has long been promoted in RFT areas in response to chronic access barriers to HM care and continues to be supported. To better understand the current status that telemental health plays in today's rural healthcare system, Lambert, Gale, Hansen, Croll, and Hartley (2013) conducted a national study of rural healthcare programs. The key findings were:

1. The scope and volume of services provided are often modest, suggesting that the business case for these programs may be weaker than the clinical.
2. Programs were able to secure funding and other supports to implement services, but their ability to maintain and expand services to meet needs is less certain.
3. Telemental health primarily addresses issues related to the distribution of providers and travel distances to care. However, there are underlying practice management issues, common to all MH practices in rural areas, which pose challenges to sustainability.
4. It is becoming increasingly apparent that telemental health technology, by itself, cannot overcome service delivery challenges

without underlying reform to the MH service system (p. 1).

Although telemental health is being increasingly used in RFT areas, the results of this study raises question about the views of advocates of the approach of telemental health in rural areas. Lambert et al. found that some advocates viewed telemental health as a panacea without understanding the underlying financial and organizational challenges of delivering MH services in rural communities. The quality and continuity of MH care through the use of telemental health in RFT areas also might be compromised. See Research Box 26.2. (See Chap. 26 for additional information on the use of technology.)

Peer Support Counselors A growing practice in mental health services is the utilization of peer support counselors. According to Jain (2013), hiring peer support counselors represents innovation in the delivery of rural mental healthcare. Peer support consists of a peer support provider, who has a lived experience with mental illness, and, having experienced significant improvements in their own condition, offers services to a peer considered to be not as far along in their own recovery process. The premise is that the life experiences of peer support counselors allow them to provide recovery support in such way that others can benefit from their experiences. “A peer support counselor can leverages shared experiences to foster trust, decrease stigma and create a sustainable forum for seeking help and sharing information about support resources and positive coping strategies,” ... “promote awareness among the target populations, and speak the same language as those they are helping as a result of shared experiences” (Money et al., 2011, pp. 4–5). In a formalized peer-to-peer program, the peer providing the support has received some level of training and has access to more intensive support resources (Money et al., 2011). A peer support counselor can become certified (i.e., Nationally Certified Peer Recovery Support Specialist [NCPRSS]) (National Association for Addiction and Drug Abuse Counselors [NAADAC], 2013).

Research Box 26.2: See Lambert (2013)

Objective: To better understand the role that telemental health plays in today’s rural healthcare system.

Method: A national study of rural telemental healthcare programs was conducted in two phases. In the first phase, a list of telemental health programs was compiled by (a) reviewing grantee directors for relevant program (i.e., Office of Rural Health Policy (ORHP), Health Resources and Services Administration), (b) soliciting nominations from a national advisory group of rural telemental health experts recruited for this study and ORHP-funded Telehealth Resource Centers, and (c) conducting extensive web searches. This process generated 150 programs that were invited to complete an online survey. Data were collected on organizational context, services provided, staffing patterns, and the areas and populations served. In phase two, semi-structured telephone interviews with administrators from 23 programs were conducted to understand the business and clinical environments in which these programs operate, their successes and challenges in establishing programs and delivering services, and the prospects for and challenges of long-term sustainability.

Results: Sixty programs responded (40% response rate), of which 53 provided a use profile of what current rural telemental health programs are doing. Based on the responses, academic medical centers are the most common settings for telemental health programs. Other common settings included community mental health centers, acute care hospitals, private vendors, Federally Qualified Health Centers, and Rural Health Clinics. Organizational uses of telemental health technology were direct patient care, consultation between providers, care management/coordination, staff

supervision, and quality improvement activities. Direct services provided included medication management, initial diagnostic evaluation, psychotherapy, crisis stabilization, involuntary commitment assessment, substance abuse treatment, and crisis management. Mental health professionals providing telemental health services were psychiatrists, clinical psychologists, clinical social workers, and psychiatric nurse practitioners (these were not mutually exclusive). Rural telemental health programs are located across a range of organizational settings: free-standing/independent facilities, networks, and large health systems. The current and future role of telemental health in the rural health system included access, reimbursement, patient and provider satisfaction, and successful use of telemental health.

Conclusion: It is important not to overpromise what telemental health can accomplish. Equally important is to recognize that telemental health can play an important role under the payment and service delivery models established or promoted under the Affordable Care Act. Telehealth may have a role to play in achieving a balance between access to care, cost containment, and meeting the needs of the population.

Questions

1. What other type of sampling methodology would you use to conduct this study?
2. What are the implications of these results for rural geographically diverse regions (e.g., Alaska, Montana, Maine, Texas)?
3. What are the limitations of this study?

Money et al. (2011) describe four models that demonstrate how peer-to-peer programs can be structured: *support group*, *peer mentor*, *community health worker*, and *peer educator*. A *support*

group includes multiple individuals meeting to share experiences. The advantage of a support group is that it provides an opportunity to learn from others' experiences and more opportunities to strengthen the social network. The disadvantage is that a support group can be difficult to start, and it requires administrative support and multiple participants. A *peer mentor* is an individual that meets with an individual on a one-to-one basis. The strength of a peer mentor model is it involves individual attention and advocacy. The limitation of this model is that it is dependent on the abilities of the peer mentor. A *community health worker* serves as a liaison between a target population and MH and healthcare providers and may not always be a "true peer." The major strength of a community health worker model is the ability to build a bridge between service providers and individuals not already in care. The chance that peers may be absorbed into a healthcare provider system and lose their peer status is a limitation of this model. The *peer educator* model is where a peer provides an educational course with discussion time. This model provides access to information as well as recognition that there are others in the same situation. On the down side, the peer educator model is a short-term intervention and does not provide ongoing support. An overall advantage of any of the models is that peer support can be delivered through multiple modalities, including in person, by phone, or over the Internet. These models can be used individually or in combination with each other, offering more than one option to clients (Money et al., 2011).

There are numerous benefits to a peer support counselor. One benefit is that peer support counselors have a perceived sense of credibility. That is, they have personal experience as a frame of reference. Another benefit is that they interact more frequently with the person in counseling than do MH professionals or others of the medical community. As a result, peers are most likely to notice changes in behavior and personality of an individual (Money et al., 2011) (see Table 26.3). In fact, Money et al. describe the roles and func-

Table 26.3 Benefits of peer support counselor

Creates an environment of credibility
Reduces stigma by providing a platform for discussion
Increases the number of social relationships for the peer
Provides education to support positive coping behaviors
Promotes cohesion between service providers and clients
Serves as a liaison between the client and behavioral health professional
Increases outreach to individuals who might not be currently using MH services
Provides information on resources available beyond the immediate peer supporter
Facilitates referrals of individuals needing professional assistance before or when a crisis event occurs
Provides benefits to the individual participant, peer supporter MH and healthcare providers, and surrounding community

Adapted from Money et al. (2011)

tions performed by a peer supporter as interconnected benefits.

Professional Licensure and Professional Credentials Professional licensure of mental health counselors, clinical social workers, and professional counselors is regulated at the state level. In other words, each state sets its own standards and qualifications. A barrier often imposed on professionals that deliver MH services is that they can only practice in the state in which they are licensed. For clients that live along a state or territory border, it may be closer for them to receive services from a neighboring state; however, to do so is prohibited by licensure laws. Gray (2011) recommends allowing licensing for multiple states in a region as a means of addressing the needs of providers along state and territorial borders. In addition, there is also variation among occupations depending on level of specialized training, certifications, and specific industries. Reimbursement to rural health clinics requires additional education and certification requirements (Eilrich et al. (2010). For example, psychologists must be doctoral level, and clinical social workers and psychiatric nurse practitioners must be master's level.

Perhaps the era of specialized training has come full circle, and there is a need for cross sec-

tor training and skills development and licensure or certification so the MH professionals and drug and alcohol counselors can effectively support individuals with dual diagnoses of both MI and substance abuse disorder, regardless of which service they are initially referred (Parliament of Australia, 2006).

Recovery and Employment

In 2000, NAMI issued a call to state agencies to increase among their ranks the number of employees with MI. The intent was to move the mental health system toward a recovery-based model. Unemployment of individual with MI is consistently and persistently high. Among clients served by public mental health systems, unemployment is more than three times that of the general population (Lutterman, 2012, 2013). Education, which is considered as a shield against poverty, has not been an effective hedge against unemployment or underemployment for those with MI (Cook, 2006). For many clients with dual diagnoses in RFT, communities reentering or maintaining employment presents an ongoing challenge (NAMI, 2012).

Often, individuals with MI may need support in the workplace. Supported employment, which is paid, competitive employment in an integrated setting with ongoing supports, is an evidence-based practice that is effective for persons with disabilities. Promising models for employment include Individual Placement and Support (IPS) Supported Employment, Assertive Community Act and Supported Employment, clubhouses, internship to employment, self-employment, and volunteering (NAMI, 2012). IPS is designed to help individuals with MI find jobs in the competitive marketplace, and it (a) tailors employment services to match the person's needs, talents, and preferences; (b) prioritizes rapid job search and placement, as well as long-term availability as long as support is needed; and (c) calls for employment services to be integrated into the individual's MH treatment plan with an employment specialist working as a member of the treatment team (NAMI, 2012). ACT is another

evidence-based program that uses a multidisciplinary team approach and offers comprehensive MH services when and wherever needed (SAMSHA, 2008). In addition to support employment, ACT provides an array of services including mobile crisis intervention to individualized support therapy to supported housing and transportation. ACT teams have small caseloads with services available 24 h a day, 7 days a week, in locations such as home, work, or community (NAMI, 2012).

Clubhouses are community-based centers that use an egalitarian, inclusive approach where club members and staff work together to operate the program. Clubhouses offer a wide range of services. Those centers that are certified by Clubhouse International offer employment services. Internships offer people with MI to gain work experience with their career goals and are usually part of an educational program. “Internships offer a low-risk opportunity to explore the fit between individual aspirations and workplace expectations” (NAMI, 2012, p. 10). An alternative to traditional work settings for people with MI is self-employment and small business ownership. These options provide flexible work hours and workplace location. In addition, they allow individuals to capitalize on their unique creativity, promote innovation, and offer the opportunity to pursue specialized talents (NAMI, 2012). Finally, a practical route to employment is through volunteering. Volunteering offers individuals with MI the chance to transition into the workforce by taking on responsibility, learning new skills, interacting with others, and receiving recognition and feedback. Volunteering provides a test run in which neither the individual nor the employer is locked into performance criteria.

These evidence-based approaches to gainful employment provide the individual with opportunity to practice the job and learn skills and employers an opportunity to assess the individual’s skills and workplace behavior. In addition, for those who receive disability benefits, supported employment provides a chance for

employment and a security net of not losing benefits. In rural areas where job opportunities are less available, these approaches can provide support to the employer and individual for implementing workplace accommodations. In the end, supported employment for individuals with MI improves.

Summary

Mental illness affects people from all walks of life; however, the extent of its impact is disproportionate in rural areas due to numerous barriers. Rural, frontier, and territory communities are diverse, with different levels of services. RFT areas are disproportionately and adversely impacted by MI and dual diagnosis because of a combination of risk factors and low service accessibility. The outcome is reflected in a potential for loss of life and loss of jobs, productivity, and income. The gaps in treatment, funding, and personnel shortages must be addressed in RFT areas. Recognizing the complexity involved identifying and implementing strategies in mental health, and substance abuse treatment in RFT areas requires that policy and funding becomes a priority. If the argument against increased funding to MH clinics and services is that it is costly, one can only imagine the cost of not providing care.

Resources

- Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT: <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>
- Behavioral Health Barometer – US 2014 (SAMHSA): <http://www.store.samhsa.gov/product/Behavioral-Health-Barometer-2014/SMA15-4895>
- Dual Diagnosis Capacity in Mental Health Treatment (DDCMHR) Toolkit – Version 4.0: http://dartmouthprc.org/wp-content/uploads/DDCMHT_Toolkit.pdf

National Alliance on Mental Illness: <http://www.nami.org>

National Association for Rural Mental Health: <http://www.narmh.org>

National Institute of Mental Health: <http://www.nimh.nih.gov>

Substance Abuse Mental Health Services Administration: <http://www.samhsa.gov>

Learning Exercises

Self-Check Questions

1. Why is there a renewed interest in integration of mental health services with primary health services in rural areas?
2. Explain what is meant by mental health and mental illness exists on a continuum.
3. How are dual diagnoses defined?

Experiential Exercises

1. Identify a specific mental illness and a coexisting mental health condition or addiction and develop an approach to address this dual diagnosis for an individual residing in a rural, frontier, or territory community.
2. Construct a framework on policy to address mental health service delivery in rural areas.
3. Identify a current mental health concern in a rural area and discuss how it is impacted by economic circumstances, cultural considerations, and regional or geographic situations.

Multiple-Choice Questions

1. Which of the following are the most commonly diagnosed mental health disorders?
 - (a) Depression and anxiety
 - (b) Anxiety and bipolar
 - (c) Manic disorder and substance abuse
 - (d) Schizophrenia and mood disorders
2. Which of the following is a primary reason that treatment for mental illness has shifted to the primary healthcare sector in rural areas?
 - (a) High costs
 - (b) Personnel shortage
 - (c) County regulations
 - (d) Community expectations
3. Fear of seeking mental health treatment in rural areas is closely associated with which of the following?
 - (a) Culture
 - (b) Stigma
 - (c) Shame
 - (d) All of the above
 - (e) None of the above
4. Which of the following is the most common reason as to why many rural residents are often reluctant to seek mental health or substance abuse treatment?
 - (a) Costs
 - (b) Lack of transportation
 - (c) Religious reasons
 - (d) Privacy
5. Which of the following can be both an asset and barrier to rural residents seeking treatment for mental illness or substance abuse disorders?
 - (a) Weather and climate
 - (b) Family size
 - (c) Protective factors
 - (d) Age
6. Which of the following is true of a peer support counselor?
 - (a) Perceived not to have credibility
 - (b) Less likely to notice changes in a peer's behavior and personality
 - (c) Have personal experience as a frame of reference
 - (d) Likely to less frequent contact with the peer than do mental health professionals
7. Which of the following statements most accurately describe the difficulty in working with dually diagnosed clients?
 - (a) Clients are too unstable
 - (b) Professional blindness

- (c) Time management problems
 (d) Direct cost of services
8. Which of the following exacerbates the shortage of qualified personnel for individual with mental illness or substance abuse disorders that live in rural areas along state lines in which the closest service provider is in another state?
- (a) The professional can only practice in the state in which he or she is licensed
 (b) The professional usually charge higher for out of state clients
 (c) The professional is likely to have less contact with the client
 (d) The professional is less likely to provide an educational course with discussion time
9. Which of the following best describe the collaborative care model?
- (a) Care coordination can be care management
 (b) Use regular monitoring and treatment with validated clinical rating scales
 (c) Use regular and systematic psychiatric caseload reviews and consultation
 (d) All of the above
 (e) None of the above
10. If disability due to mental illness and dual diagnoses is to be reduced in rural areas, which of the following needs to be addressed?
- (a) The availability of supported employment
 (b) The treatment gap
 (c) The competency of counselors
 (d) The success of consultation

8. A
 9. D
 10. B

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Key

1. A
 2. B
 3. D
 4. C
 5. C
 6. C
 7. B

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