



When There's No Place to Turn

MENTAL HEALTH SERVICES ARE A CRITICAL RURAL NEED

BY PATRICK T. REARDON

It was big news when psychologist Tobin DelGuidice arrived in Long Prairie, a hamlet of about 3,000 souls in central Minnesota. The only mental health professional in the community, he was interviewed by the local newspaper. But during his three years there, he found that his clients were uncomfortable dealing with the lack of anonymity that comes with seeking mental health treatment in a small-town setting.

“In Long Prairie, everyone knew everybody,” he said. “I had clients who didn’t want to be seen coming into my office. They’d look around to see who was around and try to get in my office in some quick, stealthy way.”

DelGuidice — now the clinical supervisor for the seven-site Caritas Mental Health Clinic program of Catholic Charities of St. Cloud, Minn., serving 19 rural counties across the central part of the state — recognized the feeling. Many times, he would find himself in social situations with people he was counseling. “If I was in a store and I saw that there was a client, I didn’t feel I could quite be myself,” he said.

There is an enduring myth, fostered by city-dwellers, that rural America is a rustic Eden where life is pleasant, calm and, well, organic. Yet, farmers, ranchers and other country folk are just as likely — in some ways, more likely — to find themselves grappling with mental

health issues, such as depression, addiction and other serious ailments. They have a much more difficult time getting treatment, however. And little is being done to bring more services to the Heartland.

MANY BARRIERS

Lack of anonymity is just one of many barriers.

There are fewer mental health professionals per 100,000 rural residents than are available to urban and suburban people. Those counselors are thinly spread across the landscape, so individuals needing assistance often have to drive long distances to find the help they need.

Indeed, more than half of the 3,075 rural counties in the nation (55 percent) have no psychologists, psychiatrists or social workers, according to a report from the U.S. Department of Health and Human Services.¹

Likewise, although detoxification is a key component in the treatment of substance abuse, 82

percent of rural people live in a county without any detoxification service, reported the Muskie School of Public Service.² In all of rural America — where, according to the U.S. Census Bureau, more than 60 million people live — there are only 235 detoxification providers, the report noted. Nearly 60 percent of these serve an area with a radius greater than 100 miles.

The figures are similarly bleak for services to children. In another 2009 study, the Muskie School reported that rural children are 20 percent less likely to receive mental health treatment than urban children.³ Four of every five rural children live in counties without a community mental health center, according to a 2005 report from the South Carolina Rural Health Research Center.⁴

Of course, many technological breakthroughs, such as telemedicine, have helped bring health services to more Americans despite physical dis-



tance. (See sidebar, page 48.) However, such breakthroughs depend upon communications advances taken for granted in metropolitan areas. Cell phone service and broadband access are available on only a spotty basis, if at all, in many agrarian areas, according to the Federal Communications Commission. In addition, the costs for these services generally is higher in rural areas.

The FCC found that nearly three in 10 rural health clinics in the U.S. (29 percent) lack access to mass-market broadband. That was a major reason less than a quarter of the 11,000 eligible rural clinics took part in a federal program to promote telemedicine, the FCC reported.⁵

Lack of health insurance has been a greater problem in the countryside than in U.S. cities. Nearly a quarter of rural residents (24 percent) were uninsured in 1998, compared with 18 percent of people living in or near metropolitan regions, according to a 2003 study by the Kaiser Commission on Medicaid and the Uninsured.⁶ Also, one in five rural residents were uninsured for an entire year, compared with one in seven in urban counties.

Complicating all of these factors is the cultural reality that most rural people live by an ethic of self-reliance. This does them well in many areas of their lives, but not when it comes to handling emotional and behavioral stresses.

DEPRESSION AND SUICIDE

An estimated 2.6 million rural residents suffer from depression, according to a study by the South Carolina Rural Health Research Center.⁷ This study found that 6.11 percent of people in rural areas are depressed, compared with 5.16 percent in urban places. The rate for rural women was higher, 7.9 percent, compared with 6.69 percent for urban women.

In 2004, a major policy paper of the subcommittee on rural issues of the President's New Freedom Commission on Mental Health noted, "Suicide rates for both rural adults and children are higher than they are for their urban counterparts. ... The suicide rate is significantly higher among elderly males and Native American youth reflecting an upward trend in recent decades."⁸

In 2002, a report in the *American Journal of Public Health* said, in the early 1970s, the suicide rates for urban and rural men were about the same, but, over the next quarter century, the figures went in different directions. By the mid-1990s, the rural rate was more than 50 percent higher.⁹

Researchers Garth Kruger and Jacque Gray found stark evidence of this rural trend in North Dakota. During a recent 10-year period in the state, at least 797 people — the equivalent of the population of a small town — took their own lives, and hundreds more attempted to do so, Kruger and Gray wrote in a 2005 study.¹⁰

The high suicide rate, experts and health professionals said, may be partly because rural people have a harder time than their urban and suburban cousins asking for help.

"Folks that live in northern Michigan are a pretty stoic, hardy lot," said Pattie Walker, the director of the emergency department at Mercy Hospital in Grayling, in an interview. "You have to be, to live in this area. It's difficult for people to admit that they have these issues."

Her hospital serves a four-county region with no inpatient mental health facilities, even in her institution. The closest psychiatrist is 70 miles away in Traverse City.

"With our own employees," Walker said, "I have tried to encourage a couple to get counseling, and they tell me: 'No one in my family has ever seen a counselor,' or 'I don't believe that works.'"

GETTING ATTENTION

About 20 percent of Americans are scattered thinly across 80 percent of the nation's landscape. This rural population often lacks the concentrated political clout of urbanized areas, and state governments, when faced with budget shortfalls, know that they'll get less popular blowback for reducing funds for services in the countryside.

"The rural programs tend to be cut first and were under-funded to begin with," said Roger Hannan, the executive director of the Farm Resource Center, an innovative "kitchen-table" program that operates in 65 counties in Illinois.

The center's outreach workers seek out and meet with rural families in their homes — at the kitchen table — to help them obtain the services

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they need. Sometimes, it's just a friendly ear. "The first thing they do is listen, listen between the lines," Hannan said. "It may be a crisis that can solve itself."



Despite the success of the 25-year-old service, a recent wave of funding cuts in Illinois forced Hannan to lay off 10 of the center's 19 outreach workers.

GETTING COVERED

"In our rural area, I know of a family who will carry their [health insurance] policy until it's time to plant," said Dianne Travers Gustafson, a Creighton University professor in the school of sociology and anthropology.

The family drops the coverage in order to have more money to pay the high expenses of getting seed in the ground, and then picks it up later. "So they're uninsured at the highest risk time," she said.

The health care reform package signed into law by President Obama is supposed to provide insurance coverage to all Americans by 2014, but experts are not sure what the impact will be.

An earlier law, the Wellstone-Domenici Mental Health Parity Act of 2008, requires that health plans for businesses charge the same co-payments and other fees and provide the same level of service for mental health as for physical health. The law covers only companies with more than 50 workers, however, and most rural people are employed by smaller businesses or are self-employed.

Advocates worry that something similar may happen with the new reform package — more rural residents may be able to obtain health care coverage, but how many people will qualify, how far that coverage will go and where services can be obtained remains to be seen.

Without question, the health care reform laws "will increase the demand for services" in rural America, said John Gale of the Maine Rural Health Research Center at the University of Southern Maine. But will the services be available? And specifically, will there be more psychiatrists and social workers working in the Heartland?

"It'll put a greater demand on an already fragile service system," Gale said.



GETTING PLACES

For rural residents, transportation can be an issue that carries financial implications. More rural residents live in poverty than city residents — 15 percent versus 12 percent, according to the U.S. Census Bureau¹¹ — and, for them in particular, getting health care — indeed, getting any place from home — can be a particular challenge.

"The in-network [mental health professional] may be in a town 75 miles away, but an out-of-network one is only 30 miles away," said Travers Gustafson. Does the patient drive further, spending more time and gas money, to obtain the less expensive service?

During a study of women in one rural Nebraska area, Travers Gustafson said many told her they "had given up going to [treatment] because they couldn't arrange a ride, or the weather was such that they were afraid to drive, or the car broke down again, or they couldn't afford the gas."

As a result, people with mental health issues can end up looking for help in the emergency rooms of hospitals that do not offer psychiatric services, like Trinity Health's Mercy Hospital in Grayling, Mich.

"They come from as far as 50 miles away," said Walker. "Oftentimes, clients don't have transportation back home, and, occasionally, they end up spending the night in our waiting room."

There is one mental health outpatient program, also in Grayling and open during business hours on weekdays, that serves the same region and offers a 24-hour crisis hotline. But anyone needing in-patient care has to drive or be driven one and a half to three hours to better-served, more urban areas.

Travel distance is an even bigger problem in larger states that are farther west — and not just for patients.

The Hill Country Community Mental Health

and Mental Retardation Center is a publicly funded, not-for-profit service for a 19-county, 22,000-square-mile region of central Texas that is home to 425,000 people (or about 19 per square mile).

In addition to its headquarters and a 16-bed inpatient unit in Kerrville, the center operates 10 mental health clinics with a staff of 200-230, including nine psychiatrists. There is only one other psychiatrist in the entire region.

"To get to one clinic that serves six counties, the client may have to drive an hour and a half or about 115 miles," said Linda Werlein, the center's chief executive officer. "The closest state hospital will be anywhere from 30 minutes to four hours from one of our counties."

Often, a client won't have transportation to the clinic. "So we have to go and pick them up and

bring them in to see the doctor, and that can take a two- or two-and-a-half-hour round trip for one of our staff members," she said.

GETTING MORE TIME

Five years ago, Hill Country began using telemedicine technology, also called e-care, to permit psychiatrists to see patients over a video link instead of in person.

The patient goes to a satellite office where he or she meets with a psychiatrist via a two-way computer video hook-up. On the screen, the doctor is able to take in all the physical mannerisms and reactions of the patient, a key element of the therapy. Every fourth session is held in person.

Telemedicine, she said, "has added at least three hours a day, and sometimes four hours a day, for serving patients for every doctor that had to

ROBOTS AND PSYCHIATRISTS: MEETING MENTAL HEALTH NEEDS IN THE RURAL WEST

BY COREY SURBER, M.H.S.

The entire state of Idaho is a federally designated mental health professional shortage area. Services are scarce in urban population centers, and in rural communities, access to mental health care is nearly nonexistent.

In February 2009, Saint Alphonsus Regional Medical Center (a member of Trinity Health) in Boise, Idaho, launched a telepsychiatry program targeting underserved, rural communities. The program addressed the top need identified in the medical center's 2005 and 2008 community needs assessments — access to mental health services.

We built on existing telemedicine technologies Saint Alphonsus had employed in the region, including remote presence robots and videoconferencing. Philanthropic funds (through Saint Alphonsus Foundation) helped us expand the menu of telemedicine services to include psychiatric care.

It works like this: Primary care providers identify and refer new patients to the program, with initial consults typically lasting an hour and follow-ups 30 minutes. The consulting psychiatrists talk and interact

with the patients via remote presence robots and/or video conferencing. The consulting psychiatrists then provide recommendations to the primary care provider the same day, and the primary care physician coordinates the patient's ongoing care and medication management.

We protect patient privacy through use of HIPAA-compliant transmission lines and HIPAA-compliant faxes when needed — and caregivers place patients in private rooms with the robot and adjust the volume appropriately.

Before telepsychiatry services were available, 90 percent of patients had received no previous psychiatric care. Instead, they had relied on primary care providers, counselors or someone else for support. The remaining 10 percent were driving to services situated more than an hour away, often in treacherous winter conditions.

While there were some initial doubts about whether patients would accept mental health care via telemedicine robots, we have found 90 percent of patients have returned after their initial visit. The scope of the telepsychiatry program thus far has included two psychiatrists in Boise working

with 35 to 40 primary care providers at facilities in five rural communities. In the first 16 months, 118 adults and 56 children have been served. Approximately 70 percent of the patients are on Medicare or Medicaid, 20 percent are privately insured and 10 percent are self-pay.

While this program has been successful in addressing a critical need, implementation has been challenging. To our west, rural partners in eastern Oregon have expressed interest in the program, but Medicaid restrictions make it difficult for non-Oregon-based providers to offer services for psychiatry patients across the state line. Credentialing of providers has also been a barrier. Legislation pending in Congress aims to address this issue. Further, although public payers have recognized the legitimacy and efficacy of telemedicine services, private payers do not consistently reimburse. Advocacy efforts would help ensure adequate reimbursement.

COREY SURBER is advocacy and community health coordinator at Saint Alphonsus Health System, Boise, Idaho.



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travel. Their bodies aren't wearing out, and the clients aren't talking to a tired doctor."

Indeed, the technology has worked so well that, in April, Hill Country began using it for the initial assessment of clients seeking treatment.

"When you're in a rural area, [telemedicine] is your salvation," Werlein said.

Matt Grimshaw, CEO of CHI's Mercy Medical Center in Willston, N.D., is exploring telemedicine for behavioral health since a staff psychiatrist left in early spring for a larger city. The psychiatrist, working with a nurse practitioner, had staffed inpatient and outpatient services. Since the psychiatrist's departure, inpatient services have been discontinued, and Mercy is providing outpatient services via telemedicine, working with a psychiatrist in Bismark. The psychiatrist makes on-site visits monthly and virtual visits in between. The hospital hopes to reopen its in-service unit, pending state and federal waivers of a requirement that inpatient facilities have an on-site psychiatrist.

"We believe we can provide a higher quality of psychiatric care by partnering with top quality psychiatrists who are probably unwilling to relocate to northwest North Dakota," Grimshaw said. He noted that the medical center has had good results with virtual oversight of patients in intensive care by intensivists in Des Moines, Iowa.

'THERE ISN'T A PLAN'

While telemedicine can provide more mental health services to rural America — in areas where the technology is available and affordable — there is no concerted national effort to solve deeper problems, according to Mohatt.

"Sixty percent of rural America is underserved," he said in an interview. "That statistic hasn't changed in 50 years."

Mohatt authored the 2004 major policy paper of the subcommittee on rural issues of the President's New Freedom Commission on Mental Health. In it, he laid out the problems of providing mental health services in non-urban regions and outlined strategies to address them.

Nothing happened.

The biggest obstacle that rural America faces, he said, is that it is low on the priority list of most public officials. For example, he noted that, at the Substance Abuse & Mental Health Services Administration, an arm of the U.S. Department of Health and Human Services, "there's not one person whose job it is to take care of rural [issues]. There are dozens for HIV."

The Bush White House failed to tackle the issue, and so has the Obama administration, Mohatt said. "There isn't a plan," he said. "If you don't have a plan, there's no surprise that nothing's being done."

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