Introduction to Mental Health Service Delivery in Rural Areas

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The following chapter, reprinted from a National Institutes of Health (NIH) publication titled "Mental Health in Rural America: 1980-1993" (Wagenfeld et al. 1994), provides an overview of the mental health services system in rural areas of the United States: its history, current status, and outlook for the future. It was selected for inclusion in this monograph because it enumerates the major categories of mental health care services available in rural areas and discusses special populations. However, it does not provide details about barriers to delivery or focus on substance abuse treatment and prevention. This introduction attempts to fill these gaps.

Although substance abuse treatment programs constitute only one category of mental health services, the categories appear to overlap. For example, Galanter and colleagues (1988) reported that over one-third of those admitted for general psychiatric care had drug abuse problems that either influenced or precipitated their current mental health status. Another study found that approximately two-thirds of those seeking admission to substance abuse treatment programs presented with evidence of an additional psychiatric problem (Ross et al. 1988). Moreover, reports of the comorbidity of depression, anxiety, phobia, and other psychiatric disorders among drug using adults are common (Helzer 1988; Regier et al. 1988; Ross et al. 1988).

Regardless of the primary diagnosis, the occurrence or co-occurrence of drug abuse and other mental health problems may be especially difficult for residents of nonmetropolitan and rural areas because availability of treatment services appears to vary with population density and proximity to urban areas. In fact, the National Association of State Alcohol and Drug Abuse Directors (Substance Abuse and Mental Health Services Administration (SAMHSA) 1994) cited rural populations as a major unmet substance abuse prevention and treatment need. Attributes of prevention and treatment services providers, clients, and the system in general contribute to this situation.

Rural areas traditionally have had difficulty in attracting and retaining psychiatrists, psychologists, and other health care professionals

(Murray and Keller 1991; Mintzer et al. 1992). Lack of opportunities for continuing education and collegial support, as well as low salaries, heavy case loads, and the generalist role discourage many health care professionals from locating in rural areas. More remote locations appear to have the most difficulty in recruiting and retaining qualified personnel (Office of Technology Assessment 1990).

When substance abuse services are available, they may be located in towns that serve as regional service centers. For specialized services, such as inpatient detoxification, one may have to travel to a city. From the client standpoint, distance and lack of public transportation are major barriers to treatment utilization (Louisiana State Epidemiology Work Group 1994). Moreover, the chronic poverty status of many rural areas has resulted in residents avoiding preventive care but later seeking more costly, intensive treatment services (Mintzer et al. 1992; O'Hare and Curry-White 1992). Avoidance of services may also occur when the service is viewed as unacceptable because it departs from or challenges the local traditions, knowledge, values, or beliefs about health problems (Human and Wasem 1991). This may be especially true with regard to substance abuse treatment programs and may be intensified by lack of client choice in selecting a compatible provider or program.

The farm crisis of the 1980s and the subsequent economic problems of rural areas have exacerbated the problem of health services access and delivery in nonmetropolitan and rural areas (Doeksen et al. 1992; Murray and Keller 1991). In 1992, the uninsured rate for nonmetropolitan residents was 15.7 percent higher than the U.S. national average (National Center of Health Statistics 1994). Several factors may account for this discrepancy, including the inability of small companies typical of rural areas to offer insurance; the higher premiums charged to workers in high-risk occupations such as farming, mining, logging, and fishing; and the low incomes of many seasonal farm laborers and rural factory workers (Mintzer et al. 1992). In addition, family efforts to make ends meet during difficult economic times can involve postponing and cutting back on expenses. Health insurance and medical care are among the first expenses to be cut or postponed (Elder et al. 1994). Even those with health insurance may find that their substance abuse treatment benefits are inadequate when confronted with a for-profit mental health care system.

Finally, the dwindling tax base brought on by the depreciation of farm lands and out-migration of residents means a decrease in local funds available for the support of health, mental health, and social services (Human and Wasem 1991). Moreover, national level legislative changes in the early 1980s resulted in a shift away from a publicly supported rural community mental health system that provided multiple services to one that focuses on those with severe mental illness. Rural hospitals have been particularly hard hit. Many have and others will close as the result of financial difficulties (Office of Technology Assessment 1990). This is unfortunate for those seeking mental, as well as physical, health care because compared with urban hospitals, a much higher percentage of mental health services have been offered through rural hospitals. Replacements for these services have increasingly fallen to for-profit providers in urbanized areas.

Although public funding is still available for alcohol and drug treatment, recovery, and prevention, rural areas tend to receive only the minimum allocations (NASADAD 1994). Two reasons are cited for this situation. First, rural areas of urban States typically lack strong representation at the State level to advocate for their needs and programs. Second, rural communities generally do not have strong ties to research universities, a valuable resource in writing and implementing the evaluation components of grant applications necessary for most Federal funds. If these conditions persist, rural areas will have to become increasingly self-sufficient in handling substance abuse treatment and prevention.

The state of service access and delivery in rural areas leads to more questions than answers. Anecdotal evidence suggests that either to compensate for the lack of treatment professionals, to fill the treatment services gap left by limited National and State-level funding, or to better address the needs of special populations, some rural areas have focused their resources on holistic, 12-step type, and/or other lay-person based programs. For example, the Sobriety Movement is reported to be having great success in some Native American and Native Alaskan communities (Alaska State Epidemiology Work Group 1995); however, these successes have not been well documented. Thus, even when rural communities are proactive in developing locally based programs and services there is a continuing need for evaluation studies.

In addition to the need for evidence of program effectiveness, other basic questions need to be addressed. What percentage of all rural drug users seek treatment? What type of treatment do they want? What

percentage are successful in securing treatment? How long do they wait? If treatment receipt necessitates relocation, does the temporary loss of one's home community adversely affect the immediate success of the treatment or result in higher rates of relapse? How can rural communities support members returning from treatment? Although the following chapter does not address these and similar questions, it does place rural substance abuse treatment in the broader context of mental health treatment and provides valuable information on how that system works. Answers to these questions and those prompted by the mental health services chapter provide a basis for future research.

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