Rural Behavioral Health Programs and Promising Practices

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Overview

The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Office of Rural Health Policy (ORHP) coordinates activities related to rural health care within the U.S. Department of Health and Human Services. ORHP has department-wide responsibility for analyzing the possible effects of policy decisions on 62 million residents of rural communities. ORHP was created by Section 711 of the Social Security Act to advise the Secretary of Health and Human Services on health issues within rural communities, including the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians and other health professionals. ORHP administers grant programs designed to build health care capacity at both the local and State levels.

In particular, the community-based grant programs within ORHP that draw authority from Section 330A of the Public Health Service Act, such as the Rural Health Care Services Outreach grant program, are mandated to "expand access to, coordinate, restrain the cost of, and improve the quality of essential health care services, including preventative and emergency services, through the development of integrated health care delivery systems or networks in the rural areas and regions". As a result of the program's legislative focus, the Outreach grant program provides funding to consortia for the direct provision of health care services as well as for community health service collaboration.

Currently there are many challenges to providing mental health and substance abuse (behavioral health) care in rural America. As such, ORHP supported a study in 2008 to examine the barriers to evaluating programs in rural and frontier behavioral health and to disseminate this information among current grantees and future applicants for the Rural Health Care Services Outreach, Rural Health Network Development, and Rural Health Network Development Planning programs that have a focus on behavioral health delivery in rural communities. The intent was to closely examine these programs in a descriptive manner and outline requirements to move these programs/practices to more rigorous scientific validation that would be valuable in demonstrating their effectiveness. This document will allow rural behavioral health programs to learn from the information gathered in this study and the value of collecting and using data to make program improvements, demonstrate effectiveness and importance of services, and find funding for sustainability.

Evidence-based Practices (EBPs) are practices that integrate best research evidence with clinical expertise and patient values (Institute of Medicine, 2001). EBPs are increasing in the field of behavioral health: consumers want treatments with proven effectiveness; providers want to increase their knowledge to enable provision of those treatments; research and funding entities look for opportunities to identify new evidence-based treatments; and, in some cases, policymakers are legislating the provision of evidence-based practices (e.g., Oregon Statute 182.525, which mandates expenditures for evidence-based practices).

Overall this shift toward the use and development of EBPs in behavioral health services is moving in a positive direction, with the end result being the provision of more effective and standardized behavioral health treatments. However, many of these EBPs are tested in urban areas, and are not easily adapted to rural areas without losing key components of the tested practice.

Due to the difficulty of developing and evaluating EBPs, the term, "promising practice," has been used to refer to behavioral health practices that do not yet have the evidence-base to be considered EBPs, but which appear to be effective based on a less stringent definition of research evidence (e.g., using a comparison group that is not well-matched to the treatment group) or preliminary and/or simple data evaluation. The term, "best practice," is used to refer to a practice which is generally thought to be effective based upon anecdotal evidence, but for which objective data is lacking. Without some degree of data and evaluation to support the effectiveness of a practice, it is difficult to develop an evidence-based practice.

A *practice* is defined as a specific procedure that can be generalized to targeted situations. For example, in using a specific depression screening questionnaire, there are standard procedures to follow (e.g., a specific order of questions, a specific method of scoring the responses). This screening questionnaire may be used in a variety of settings, with a variety of patients, but the reliance on a specific procedure makes it a practice. In contrast, a *program* encompasses multiple practices, activities, and strategies. For example, a "Depression Awareness Program" would not only incorporate the practice of depression screenings, but would use targeted behavioral health education, outreach, health fairs, and marketing, which are all part in parcel of a program and specific to the target population. A program may be an EBP, promising, or best practice if program variables can be generalized to different populations and/or settings.

Although there are a number of interesting and novel behavioral health practices currently being implemented in rural America, there are fewer practices that are evaluated and tested for their effectiveness than in urban areas. Much of the evidence for the effectiveness of these practices comes from subjective experience and observation, rather than data tracking and analysis.

This report documents a study to identify innovative rural programs (i.e., sets of practices, activities, and strategies), and uses the results to suggest basic tools for rural organizations to embark upon the steps necessary to move a program that is perceived to be effective into a promising practice. Achieving the status of promising practice is beneficial to programs because it provides evidence of the program's effectiveness to a target population and funders who may invest in the program, and also enables other rural programs to adapt and use the program in their own community. This document will provide an overview of tools such as community building, grant-writing, data collection, and program definition, which may prove useful to organizations that are interested in transitioning their unique and innovative behavioral health programs to promising practices.

In the initial stage of this study, the Western Interstate Commission for Higher Education (WICHE) Mental Health Program identified programs in rural behavioral health. WICHE staff spoke with 62 rural behavioral health and substance abuse providers around the country who had developed novel and innovative programs to improve behavioral health services in rural areas. Although most programs collected some form of data, few programs utilized those data to determine their programs' effectiveness. Over the course of these interviews, most organizations reported needing additional resources and knowledge in order to evaluate the effectiveness of their programs.

- Many programs reported a lack of staff time and funding to support program evaluation and/or research activities. Overworked staff members are unable to set aside time for data-related activities, such as the development of data collection procedures, data collection itself, and data analysis. In addition, staff members do not have time to document program-related activities, or apply for funding to support program and evaluation activities.

- Finding assistance from outside researchers with expertise in research design, data collection, and program evaluation is also a challenge, as most programs do not have the financial resources to support external consultants. Thus, rural organizations wishing to evaluate the effectiveness of a program are in a double bind – they often do not have the time to develop a data collection and evaluation procedure, and also do not have financial resources to hire anyone to assist with this process.

- Even if programs do have the staff time to devote to evaluation activities, they often do not have the expertise to carry out those activities. Providers in general, and rural providers specifically, are often not trained in research design, data collection and analysis, and program evaluation. In addition, providers often do not have knowledge or experience with grant-writing (e.g., where to identify grant opportunities, how to apply for them, and how to write grant applications). Without successful grant-writing opportunities, it becomes nearly impossible to fund research and evaluation efforts.

- A further hurdle in a program's ability to become a promising practice is the lack of understanding as to what constitutes a practice. Ten percent of organizations (7) responded to WICHE's initial call for nominations by sending information about the organization as a whole; nominating a group of providers or a facility rather than a method of providing treatment or in some way ameliorating the problems facing individuals who need behavioral health services in underserved rural areas. Some programs cannot reach the status of promising practice not only because they do not have data, but also because of a lack of understanding as to what constitutes a practice.

This document is primarily targeted toward providers, but is meant to apply to a range of individuals:

- *Providers* can learn about data collection and analysis, community engagement, and grant-writing.
- *Policy makers* can learn what rural organizations need to implement and develop promising practices, and how this information is instructive for legislative changes to support these efforts.
- *Researchers* can learn what providers need in the way of research tools to enable effective evaluation of rural practices (e.g., survey design assistance).
- *Consumers* can learn what to look for in order to evaluate whether a given practice is effective in their treatment and whether it would be a good fit for their behavioral health concerns.

The intent of this document is to provide a starting point for rural stakeholders to collaborate and ensure innovative practices demonstrate effectiveness based on sound science and have the funding necessary to sustain their activities.

Introduction

Mental illnesses affect up to 1 in 5 individuals in the United States (U.S. Department of Health and Human Services, 1999). When compared to major physical illnesses, such as cardiovascular diseases, cancer, respiratory conditions, and infectious diseases, mental illness ranks second in the calculated burden of disease (i.e., the number of years of life lost to premature death and years lived with the disability; Murray & Lopez, 1996). While often perceived to have minimal influence on an individual's life, mental illnesses are severely disabling. The disability associated with major depression is equivalent to the disability associated with blindness or paraplegia, and the disability associated with active psychoses seen in schizophrenia is equal in burden to quadriplegia (U.S. Department of Health and Human Services, 1999). A recent report by the World Health Organization (2008) indicates mental illnesses are the biggest health burden in North America, largely due to disability which results in a loss of productive years of life.

Behavioral Health in Rural America

Approximately 20 percent of the United States population is affected by behavioral health issues each year (Kessler et al., 2004), and although the rate of behavioral health problems does not differ substantially between rural and urban areas, the experience of mental illness differs dramatically (Mohatt, Adams, Bradley, Morris, 2005). The prevalence of and entry into care for behavioral health problems is generally comparable in rural and urban populations, but the quality of care that rural patients receive for behavioral health problems may be poorer, particularly for residents in outlying rural areas (Fortney, Rost, & Zhang, 1999; Kessler et al., 2004). Rural Americans with behavioral health disorders are significantly less likely to receive any type of treatment for their behavioral health problems than urban and suburban Americans (Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005). Individuals living in rural areas are significantly less likely than their urban counterparts to receive specialty behavioral health care (Wang, et. al. 2005) and more likely to receive general medical care only or human services only (e.g., pastoral counseling) (Wang, Demler, Olfson, Pincus, Wells, & Kessler, 2006). Unfortunately, the likelihood of receiving minimally adequate behavioral health care in the general medical sector and human services sector is substantially lower than in the specialty behavioral health sector (Wang, et. al. 2005).

For the past 40 years, 60 percent of rural America has been underserved for behavioral health needs (New Freedom Commission on Mental Health, 2003), and more than 85 percent of the nation's behavioral health professional shortage areas are located in rural America (Bird, Dempsey, & Hartley, 2001). Individuals living in rural communities are faced with three distinct burdens to adequate behavioral health care: accessibility, availability, and acceptability (Mohatt et al., 2005; New Freedom Commission on Mental Health, 2003). In terms of accessibility, rural residents typically do not know when they need behavioral health care, where they can find that care, and what care options are available to meet their behavioral health needs (New Freedom Commission on Mental Health, 2003). When they do find behavioral health care, it is not uncommon for individuals in rural areas to travel hundreds of miles to access those services. The availability of behavioral health providers in rural areas is too limited to support urban models of service delivery, in which individuals needing behavioral health services have a variety of behavioral health providers from which to choose. In addition to physical barriers to behavioral health care, rural residents also face psychological barriers. Many Americans attach stigma to having or seeking help for behavioral health problems. This stigma is particularly detrimental in rural areas where there is little to no anonymity in seeking behavioral health services (Mohatt et al., 2005). These psychological barriers severely limit the acceptability of behavioral health services in rural areas.

Challenges Confronting Rural Evidence-Based Practices

The behavioral health care barriers faced by rural Americans make behavioral health care delivery in rural areas substantially different than in urban areas, which is a particular challenge for creating evidence-based practices for and delivering evidence-based practices to rural residents. In recent years, evidence-based practices (EBPs) have emerged as a means to ensure quality behavioral health care among individuals suffering from mental illnesses. EBPs have been extremely successful in treating mental illnesses. However, most EBPs are developed in urban areas and tested on urban residents, with little, if any, thought given to how they might be implemented in rural areas where resources are much scarcer. The drastic differences in behavioral health care availability, accessibility, and acceptability between rural and urban residents make it challenging to conduct many EBPs in rural areas, leading to a strong need to develop rural-specific EBPs, and/or determine whether and how existing EBPs can be modified to produce similar treatment effects in rural areas as are observed in urban areas.

Unfortunately, a majority of rural areas lack the resources needed to develop and sustain rural-specific EBPs. Rural areas are already underserved and underfunded, and most rural behavioral health professionals do not have the time or training to plan and conduct clinical trials, or to analyze and document results from scientific studies. Even with time and expertise available to carry out and document scientific studies of rural-specific practices, rural behavioral health services often do not have the funds to carry out pilot studies necessary for obtaining larger grants. In many rural areas it is therefore a challenge to carry out large-scale clinical trials necessary to test the effectiveness of rural programs. In addition, few agencies provide funding opportunities to individuals outside of academic centers, which once again puts rural areas at a disadvantage for developing new EBPs specific for rural areas, or ensuring EBPs are effectively adapted for rural areas.

The fact that rural behavioral health providers do not have many resources to implement EBPs, or to develop new EBPs leaves rural providers facing a real challenge to providing EBPs for rural residents. However, many rural providers have developed programs specific to their areas, which may be quite successful in improving the availability, accessibility, and acceptability of behavioral health services in rural areas. Rural providers are in a better position to understand the unique needs of their communities, and many have adapted their programs and treatments to meet those needs. Unfortunately there is no medium for sharing this knowledge, and it often remains isolated in specific communities, with few resources available for documenting and publicizing the effectiveness of these unique rural programs.

Goals

In response to the need for technical assistance in determining a program's effectiveness, WICHE conducted a study to a) identify rural programs that were attempting to meet a behavioral health need in a rural area, and b) determine the general resources these programs needed to move their programs toward promising practices. This process included a solicitation for nominations via a web-based survey, and follow-up interviews with key individuals from each program. The end result of this process is a snapshot of approximately 60 rural behavioral health programs throughout the country, and a more detailed understanding of what rural programs need to do to become promising practices.

Methodology

The identification of rural behavioral health programs involved a multi-step process that first solicited nominations for novel and innovative programs, and then collected additional information about the programs through a survey and follow-up interviews. Below, is a discussion of the procedure for soliciting nominations, surveying, and interviewing each of these programs.

Reaching Programs/Practices

Criteria were not given for the type of programs to nominate for inclusion in this study (e.g., hotline, outreach), other than the criteria that the program have a positive impact on the behavioral health of individuals living in rural areas. Nominations were solicited via e-mail announcements distributed to national rural health organizations (the National Association for Rural Mental Health, the National Association for Rural Health, the National Association of State Mental Health Program Directors), national rural behavioral health funding agencies (Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration), as well as organization-specific contacts such as the Rural Assistance Center and the WICHE Mental Health Program. The purpose of these e-mails was to ensure broad distribution of the announcement to rural consumers, providers, and policy makers.

The announcement stated the goal of the survey was to identify practices that were successful in meeting a behavioral health need in a rural area. The definition of "meeting a behavioral health need in a rural area" was purposefully vague. Potential respondents were informed "meeting a need" could include increasing access to and/or availability of behavioral health services, increasing awareness about behavioral health issues, recruitment and/or retention of behavioral health providers, treatment of a behavioral health problem, and prevention services, among others. The diversity of programs responding to the nomination indicates there are very diverse behavioral health needs in rural areas, and a large number of ways to meet those various needs.

The Survey

Individuals who nominated programs by responding to the survey answered a series of questions designed to create a comprehensive summary of the program, and determine whether the programs had any data on their effectiveness. The survey is included as Appendix A and included categories of questions such as: contact information, characteristics of the nominated program, characteristics of the targeted population, training of staff, documentation of program-related information, and data collection/research capacity.

Phone Interviews

Phone interviews were conducted with 62 organizations that completed the survey, to collect more information on the nominated programs. Organizations that started but did not complete the survey, or did not respond to requests for phone interviews, were not interviewed. The interviews focused on further understanding the programs, and included additional questions, such as those directed at the sustainability of the program, and its uniqueness. The list of questions used for these phone interviews appears in Appendix B. In addition to these standard questions, phone interviews also included program-specific questions whose goal was to clarify responses given on the survey.

Site Visits

Eleven programs were selected for site visits by the project team and project officer at the Office of Rural Health Policy. In cases where the program was confined to one location, these site visits included an in-person tour of the program and meetings with essential program staff. In cases where the program was more distributed, a phone call was conducted, including as many staff members as possible. The goal was simply to get a broader picture of the programs by speaking with people not on the initial phone interviews (providers, directors, consumers) and to visit the program sites. Programs were selected for site visits based on geographical distribution, as well as the type of program it represented (e.g., hotline, integrated care clinic, etc.). The goal of the site visit selection process was to gain an in-depth view of a variety of programs throughout all regions of the country. Therefore, a geographically and topically diverse set of programs was selected for the site visits.

Overview of Nominated Programs

Sixty-nine programs from across the country completed the initial survey. The programs, representing 32 States, were spread across all four Census regions, and all nine Census divisions. Figure 1 shows the locations of these programs (note that some locations nominated more than one program, so there are fewer than 69 locations in the figure). Although there are likely substantially more behavioral health programs in the U.S. specifically designed to serve rural areas, the fact that respondents represented all areas of the country suggests the programs described in this document are somewhat representative of the types of rural behavioral health programs implemented in rural areas.

Figure 1: Locations of organizations that completed the initial survey

Categorization of Nominations

After learning about the nominated programs, it became clear they fell into one of eleven categories, based on the type of program and/or population being served. Some programs fell under more than one category, but all were able to be encompassed by the categories below.

- Programs **adapting EBPs for rural areas** found ways to carry out existing EBPs in rural areas, despite being unable to replicate programs with full fidelity.
- **Community education and outreach** programs educated individuals in the community about behavioral health issues.
- **Court teams** aimed to keep individuals with behavioral health issues from returning to the justice system.
- **Crisis services** programs provided care in some way for acute behavioral health problems.
- **Hotline** programs used telephone services to provide support to rural residents with behavioral health concerns or issues.
- **Integrated care** programs blended physical and behavioral health services in some way.
- **Peer support** programs used peers to provide basic treatment or support to individuals with mental illnesses.
- Programs serving **special populations** targeted interventions to a particular population, such as **children** or the **elderly**.
- **Telemental health** programs used phone or video conferencing to provide behavioral health treatment.
- **Training** programs educated future rural behavioral health providers.

Themes of Robust Programs

After reviewing the survey responses, talking with programs, and conducting the site visits, a few themes emerged as being indicative of a program's success and ability to serve its rural community. Each of these themes is described, below. These themes are used in the program descriptions in Appendix C to highlight each program's particular strengths, and are also expanded upon in the next section, to describe how rural organizations in general can strengthen their programs in each of these areas in an effort to develop their unique practices into promising practices. The interview and selection process led to insights into how programs can excel in each of these areas, and begin to develop the data collection and evaluation tools needed to become a promising practice.

Relevance to Rural

A program's relevance reflects its specificity to a rural community. Some programs bring much-needed services to rural areas, but it is unclear whether the programs were designed for or adapted to the rural area. A program successful in its relevance to rural communities develops a program specific for a rural community, or implements an established program in a way that is specifically adapted for a rural community.

Impact on Rural

A program that increases the availability, accessibility, and/or acceptability of behavioral health services in rural areas has a successful impact on rural communities. A program with high impact on rural is addressing one or more of the barriers to behavioral health services in rural communities.

Sustainability and Expansion Capability

Sustainability and expansion capability reflects the awareness of and ability to acquire long-term funding for the program. Rural programs are dependent on a sustainable and expandable source of funding for their programs. Some highly promising rural programs cannot continue or expand due to lack of funding. One feature of programs that are successful in meeting a rural need is a reliance on multiple funding sources, and creativity in seeking and obtaining new funding.

Capacity

A program's capacity reflects the extent to which a program's staff has, or is able to obtain, the qualifications necessary to accomplish the goals of the program. Programs that demonstrate success in program capacity have a highly qualified staff, and provide opportunities for staff to gain additional training in topics specific to the program. For example, providing or supporting additional training in elderly behavioral health issues can substantially improve staff qualifications to implement a behavioral health program for elderly individuals in rural areas.

Documentation of Program Information

Program documentation refers to the internal and external materials programs use to describe and/or advertise their services. Although most organizations have policy and procedure manuals for the organization, a majority of programs lack formal, internal program documentation, such as a procedure manual for the nominated program, to allow for replicating the program in other communities. However, programs that successfully document program information generally have external marketing materials, and have developed effective efforts to communicate with key audiences and potential funders in their respective communities.

Effectiveness

A program's effectiveness is dependent on the extent the program tracks and uses data for decision-making. Few programs collect data on their effectiveness, know how to begin collecting data, and know how to use data to evaluate the program's effectiveness. Lack of data is a limitation in creating a promising practice.

Community Engagement

Community engagement reflects the degree to which a program involves multiple stakeholders from the community in its development, execution, and expansion. Programs included in this document tend to be strong on the other themes when they have a high degree of community engagement.

Developing a Promising Practice

The seven characteristics of successful programs, as defined by this study, provide a foundation by which programs can take additional steps to move toward promising practices. A majority of programs already have strengths in some of these areas. For example, a program may have engaged community members since its inception, and may have excellent staff capacity for the program. Programs should use these seven characteristics to assess where their programs excel and where they might target further development. The initial study of rural practices highlights the fact that rural programs already have strengths in some of these areas, and this section describes, in brief, some of the steps organizations may take to improve their program in each of these seven areas. The topics of effectiveness and sustainability came up repeatedly as areas where programs wanted more support. The "Focused Technical Assistance" section is a supplementary section at the end of this document devoted to these topics.

Relevance/Impact on rural behavioral health

One of the first things an organization needs to do to move its rural practices forward is to determine what the relevance is to the rural community it serves. Most organizations interviewed have mission statements for the organization as a whole, but very few have formal mission statements for the programs they nominated. Identifying the impact a practice will have on a rural community is an essential first step in creating and testing a promising practice. There are three steps to improving a practice's relevance to and impact on rural behavioral health: Defining what is rural, defining the practice, and identifying the practice's goals.

What is rural?

The definition of what constitutes a rural practice is not static. "Rural" can and often does mean different things based on where an individual is located and who is using the term. For example, rural Pennsylvania and rural Alaska are two very different places with highly unique obstacles to providing behavioral health services for individuals living in those communities.

The most common definitions of rural come from the Census Bureau and the Office of Management and Budget (OMB), but there are more than a dozen different definitions of rural. Both the Census Bureau and the OMB have slightly different definitions of rural, and the definition used may have an impact on the funding of the practice, or the funding opportunities available to the practice. For example, the Census Bureau defines an urbanized area or urban cluster as a core region with a population density of at least 1,000 per square mile surrounding regions with a population density of at least 500 people per square mile. Rural areas are those outside of urbanized areas or urban clusters. The OMB defines an urban area, or Metropolitan Statistical Area, as a central county with at least one urbanized area, and nearby counties where 25 percent of individuals commute into or out of the core county. Rural areas, or non-Metropolitan counties, are those outside of the Metropolitan Statistical Areas. Thus, the difference between the definitions is largely an outcome of the different ways of defining urban areas. For a more thorough discussion of this topic, refer to the Rural Assistance Center (RAC) online resource page regarding the definition of "rural" and the related tool for determining eligibility based on these definitions of "rural": http://www.raconline.org/info_guides/ruraldef/. To view the rural geographic eligibility for the Office of Rural Health Policy programs, please refer to: http://www.hrsa.gov/ruralhealth/.

Defining "program"

The definition of a program is an essential starting point to developing a promising practice. A promising practice is not simply a group of providers offering services in an underserved area, nor is it simply bringing a service to a rural area not already present (e.g., adding a substance abuse treatment provider to the organization). When defining a program, for evaluation or funding, it is important to have a program in mind that is meant to improve a specific, measureable outcome on behavioral health in a rural community and has yet to be identified as having a positive effect on the community. For example, increasing the number of individuals screened for depression, increasing the number of graduates from a rural training program, and decreasing the wait time for an initial visit are all specific, measurable outcomes that might result from implementing new programs. Developing new procedures or programs to meet a specific need in a rural area and improving these aforementioned types of outcomes, constitutes a testable, rural program that could move toward a promising practice with a well-designed study.

Identifying program goals

In defining a program, it is important to have specific goals in mind as to what the program will accomplish in order to meet a rural need. In rural areas, the most commonly discussed barriers to treatment include: accessibility, availability, and acceptability (Mohatt, 2005). Rural residents often have trouble accessing care – providers may be hundreds of miles away. The availability of behavioral health providers in rural areas is often too limited to support urban models of service delivery (e.g., evidence-based practices tested in urban areas). In addition, the stigma many Americans attach to having or seeking help for behavioral health problems is particularly detrimental in rural areas where there is little to no anonymity in seeking behavioral health services (Mohatt et al., 2005).

For a program to meet a need in a rural area, it will generally address one of these three barriers to treatment. A program that cannot define how it is specifically addressing a rural need in a novel and innovative way will have a difficult time convincing funding agencies to contribute to the development and testing of the program.

Community Engagement

One key feature of programs successful in other areas is the engagement of many different stakeholders within a rural community. Programs that effectively address rural behavioral health needs incorporate a number of different agencies, providers, and often consumers into their programs, whether they are just starting out, or have been serving rural communities for decades. This engagement of communities demonstrates the community understands and is supportive of the need for the program. Furthermore, active engagement demonstrates the program is able to successfully market what it does to the community, thereby increasing awareness of the services provided and how to access them. The key in building more community engagement is to realize others in the community are also interested in building connections.

Ensuring the need will be met

Bringing a range of organizations and individuals to discussions about a program's goals and impact on the behavioral health of a rural community ensures the program will effectively meet the community's needs. In addition, having a number of different organizations invested in the program will help ensure its longevity and bring additional areas of expertise to the table. Some of the programs identified have monthly or quarterly meetings in which various organizations in the community come together to discuss their work and to find ways to better meet the unique needs of their community. Often, these community discussions can help a program identify sources of funding it would not have found otherwise, make connections to evaluators, and help a program gain the trust and respect it needs to thrive in the rural community.

Getting stakeholders involved

Many programs with a good deal of community engagement started by simply picking up the phone and/or making an in-person visit to local providers, consumers, policy makers, and/or researchers. Most programs were met with enthusiasm when they took this approach, and set up groups of community members who meet regularly to discuss community behavioral health issues. Programs successful in engaging the community work hard to maintain these connections despite busy schedules, staff turnover, and lack of resources.

Programs successfully engaging their communities also provide communities with information about behavioral health in general, and their program specifically. By engaging communities in this way, these programs are able to get valuable knowledge into the community and decrease stigma in the process of educating communities about behavioral health issues. For example, programs may provide their staff members as community educators, who go to area primary care providers (e.g., doctors and nurses), housing communities, church groups, schools, etc. to teach people about behavioral health issues. The programs may offer free behavioral health screenings at hospital health fairs and set up booths at community events. Each program sees these connections as vital to its success, and as observed during the nomination and interview process, these community connections are essential to a program's sustainability and impact in the community.

Connecting with researchers and evaluators

A few of the identified programs have connections with researchers and/or evaluators at local universities or colleges to assist with data collection and analysis, and/or grant-writing. These connections are fewer than the connections with other stakeholders in the communities; some programs note the cost of using a researcher and/or evaluator to help with evaluation as a major hurdle in connecting with these individuals.

Some organizations already have ties to local universities and colleges. For those organizations that do not have existing ties to a higher education institution, a perusal of faculty with interests in Psychology, Medicine, Social Work, or similar area on a campus' web site will generally turn up an email address or phone number with which to initiate contact. These connections can be local, within the program's community, or outside of State or regional boundaries. As with connecting to other stakeholders in the community, the program needs to take charge of building these connections with researchers to ensure it has the expertise needed to evaluate the impact of the program in the rural community.

Although it can be a hurdle to find additional funding to support an evaluation when an organization is already underfunded, there are a few ways to address this issue. The first is to include a researcher or evaluator in a grant application. Some individuals may be willing to help with the grant application if they will be a part of the evaluation process. A second option is to send a request to a Psychology, Medicine, or Social Work department, asking whether or not there are any graduate students who may be interested in helping with evaluating and testing the program as a part of their graduate work. Most departments have e-mail distribution lists, and it is not uncommon for requests for this type of help to be distributed to faculty and students via email. A third way to connect with researchers is at national conferences, such as the annual meeting of the National Rural Health Association (NRHA) or the National Association for Rural Mental Health (NARMH). Given the existence of computers, phones, and the internet, it is not necessary for programs to connect solely with researchers at nearby universities. Some programs interviewed are thousands of miles away from their evaluators.

Capacity and Documentation

In order to be a promising practice, a program must document its practices so that other organizations can carry out those practices in accordance with the original program and so that the program is able to advertise its services to the community. Closely related to this idea of documentation is the definition of staff roles, and having the appropriate staff capacity to carry out the specified practices.

Specifying details

It is important to document the program or practice in as much detail and as clearly as possible, so that someone else could replicate the program based on documentation alone. The following questions can be helpful in getting started with this documentation process:

- Who is the target population?
- What are the main components of the program?
- Where does the program take place?
- When does the program happen?
- Why is the program needed?
- How does the program happen (e.g., what are staff members' roles)?

Marketing program services to communities

Once a program appears to have positive effects, it is important to start marketing the program to both the local community, and the larger rural behavioral health community. Local marketing can be done by developing a brochure, handout, or some other marketing tool (e.g., a magnet or pen) to deliver to organizations in the area that may have an interest in the program. This brochure/handout should be succinct, summarize the main details of the program, and provide contact information (such as a phone number, e-mail address, or Web site) for people who wish to know more about the program. Once developed, this brochure/handout can be distributed to relevant organizations in the community. For example, a crisis line may distribute a handout describing their services to local hospitals, schools, law enforcement offices, nursing homes, faith communities, and businesses.

In addition to marketing the program to organizations within the community, it is also important to market the program to other organizations with interests in rural behavioral health. Sending out e-mail notices of the program to organizations with similar interests can spread information about the program. The Rural Assistance Center (RAC) Online provides a number of potential avenues for marketing programs. In addition to specialty conferences (e.g., the annual meeting of the American Psychological Association), conferences such as the annual meetings of the National Rural Health Association (NRHA) and the National Association for Rural Mental Health (NARMH) offer additional venues for marketing programs that appear to be effective. Presenting a poster or sponsoring a booth at one of these conferences can be effective methods to ensure others in the larger rural and behavioral health practice community are aware of the program.

Defining staff roles

It is important to demonstrate how the program staff is qualified to perform the role for which they are assigned. Collecting information on the characteristics of program staff (e.g., their education and experience), how they were recruited and hired, their job descriptions, the training they received to perform their roles, and how performance is tracked via supervision protocols will help define staff roles. By defining staff roles, a program demonstrates the staff capacity to carry out program activities as they were designed.

Importance for replication and evaluation

In order to ensure replicability of a program, it is essential to have a rigorous documentation of the details of the program. Program documentation serves two purposes: it helps an organization implement a program consistently, and it helps individuals outside the organization replicate the program.

Program documentation is also necessary when applying for funding to support the program's goals (or its evaluation). Carefully documenting the program's implementation facilitates the process of writing grants and cuts back on the staff time needed to apply for funding opportunities, since much of the information needed for the grant will be written before grant-writing begins.

Effectiveness

The effectiveness of a program can only be measured through data collection. Although it is a good sign for a program to receive positive feedback from the individuals served and for program staff to notice a positive impact, these observations are not sufficient for the purposes of defining a promising practice.

Developing a data collection/evaluation plan

"An evaluation plan is a lot like an architect's plans for a house. It is a written document that specifies the evaluation design and details the practices and procedures to use to conduct the evaluation." (U.S. Department of Health and Human Services, 2010). One way to begin developing an evaluation plan is to answer the question: What is important to know or demonstrate about the practice? Then, after answering this question, develop objectives in measurable terms. For example, rather than asking whether a depression screening questionnaire is effective, focus the question to a measurable outcome, such as, "Is the depression screening questionnaire leading to more referrals to behavioral health providers?" It is important to focus on the original purpose and related goals of the program when developing an evaluation plan to determine whether or not a program is effective.

Assessing effectiveness

Once a program has an evaluation plan and has collected data, statistical analyses are needed to determine whether or not the program is effective. As a result of limited resources and manpower, rural programs when compared to urban programs do not readily have expertise in statistics or the time to learn new skills in experimental design and analysis. As noted in the preceding section titled, "Community Engagement", connecting with students and researchers at local universities is one way to supplement research and evaluation knowledge within a program. Often, a student in a graduate program may be interested in assisting with an evaluation, in order to gain access to data for a thesis or dissertation. Making connections with local researchers expands the range of available knowledge and may provide a means for assessing a program's effectiveness that would not otherwise be available to a rural organization.

Sustainability/Expansion

A program needs to have a long-term plan for funding to be a sustainable program. Some innovative programs identified lacked a long-term plan and had terminated or were close to terminating by the time of the interviews. The most successful programs with regard to sustainability and expansion gave thought to how the program would be sustained before it was implemented; a sustainability plan is a part of the initial development of the program.

Sustainability and expansion success is closely related to a program's successful engagement of the community. Often, a program is sustainable because of its ties to other community programs. In some cases, programs are successful in funding the program solely from contributions from other community organizations.

Developing a sustainability and expansion plan

Having a sustainability plan in place from the beginning of a program's development is essential for the long-term ability of a program to serve its community. Often these plans include procedures such as getting Medicare or Medicaid reimbursement for non-traditional services; getting services at reduced or no cost from other organizations in the community; creatively applying for funding from local, State, and Federal sources; and contracting with other organizations in the community to provide essential services.

Based on WICHE's discussions with the nominated rural programs, the most robust sustainability plans form when community stakeholders are involved in the creation and execution of the sustainability plan. Community stakeholders who are involved from the beginning are able to share their own sustainability plans, help identify and connect programs with sources of funding, as well as donate their own resources to the program. Resources from stakeholders can appear in the form of funding and also in the form of donated time, services, skills. Some programs are sustainable because they are able to rely fully on small contributions from other community stakeholders, who perform a critical function for the program.

Applying for funding

There are myriad funding opportunities to support a program's expenses. Often these funding opportunities come from Federal entities, such as the Health Resources and Services Administration, Office of Rural Health Policy, the Centers for Medicaid and Medicare, and the Substance Abuse and Mental Health Services Administration. Additionally, funding comes from State offices, such as the Division of Behavioral Health, or the State Legislature as well as from hospitals, providers, private health foundations or others within a rural community.

Many programs in existence for years report using a mix of funding resources to get the program started. Over time, as the program's goals solidified and its role in the community became more apparent, some programs were able to rely on funding from one or more sources, such as a local hospital or Medicare/Medicaid.

Programs that submitted applications and are highly successful in obtaining funding are quite creative in the types of funding agencies and grant opportunities they target. Some organizations report watching out for grant opportunities in many different areas (e.g., housing-related grants), and often join with other community agencies to apply for these diverse opportunities (with great success).

Focused Technical Assistance

The Focused Technical Assistance section provides more detail regarding the development of three key characteristics, which the rural programs included in the study struggled with, and are necessary to create a promising practice: relevance to rural, effectiveness, and sustainability and expansion capacity. All programs had varying degrees of strength in areas such as community engagement, or staff capacity. However, all programs spoke to a need for more data on their effectiveness, and additional funding to expand the program and make it more sustainable. Therefore, this section focuses on these two areas, as well as relevance to rural (specifically, definition of a "program"), which was noted by the initial nomination process as an area for which some programs needed assistance, due to confusion over the type of program that can become a promising practice.

Relevance to Rural Communities

As noted above, a program's relevance to rural is apparent in its ability to affect the availability, acceptability, and/or accessibility of behavioral health care in rural areas. Identifying the relevance to rural communities is the first area to target in order to develop a plan for effectiveness research, as well as for securing program funding. If a program is not clear on what its goals are, it becomes very difficult to know where the program is having a positive effect on rural communities.

The program definition offers the best opportunity for explaining a program's relevance to rural communities. In describing a program, focusing on the practices it encompasses (as defined in the Overview) and its utility for rural behavioral health are key features of the program definition. The program definition should be clear, concise, and describe the main components of the program and its impact on rural behavioral health. Appendix C provides program descriptions for a variety of program types identified in this study. These descriptions cover all the components of a rural behavioral health program definition and serve as an example on how to describe the program clearly and concisely. The program description should identify the organization that houses the program. It should include a statement about the type of services provided, and the community served. It should highlight the key practices in the program, the relevance to rural communities, and any data relating to the program's effectiveness. It should also note any connections to other stakeholders that enhance the program's reach or relevance to the community.

Additional resources

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices (NREPP) is an additional resource from which to gather additional examples and descriptions of effective behavioral health program descriptions: http://www.nrepp.samhsa.gov/ViewAll.aspx.

Effectiveness

To achieve the status of a promising practice, programs must collect data and use them to determine the impact of the program. This measurement of effectiveness will demonstrate to providers whether a program is on the right track in solving a particular behavioral health problem in a rural area (i.e., whether or not the program is meeting its goals, as defined by its relevance to rural), demonstrate to consumers whether they should seek out that program over another, demonstrate to policy makers whether they should promote widespread use of the program, and demonstrate to funding agencies whether the program is worth their investment. For these reasons, data are essential to a program's development and viability. Programs must collect data to reach the status of a promising practice, but perhaps more importantly, data are essential for program staff to determine whether or not a program is effective in meeting its goals.

The Administration for Children and Families, Office of Planning, Research, and Evaluation has published a guide to program evaluation, written for program managers, that is an exceptionally valuable resource for individuals in need of assistance in program evaluation (2010). This guide was developed and maintained to explain the topic of program evaluation and give guidance on how to conduct a program evaluation and discuss the results. The following sections highlight some of the main points that are complementary to the aforementioned guide for rural behavioral health programs, and expound on the information based on the results of the study and the needs of rural behavioral health programs. The full guide provides substantially more detail on the proper collection and use of data.

Data collection

There are a number of different types of data to collect during the evaluation process depending on the program goals, objectives, outcomes, and the impact the program intends to have. Any information collected can serve as data, even a simple count of the number of clients/patients who receive services on a given day, month, or year. Data may include the number of participating sites in a program, the cost of the program, changes in knowledge and/or behavior, or a program's return on investment. The fact that anything can serve as data is important to emphasize because most organizations are collecting information all the time (who is and how many people are using services, how they are paying for services, the length of treatment, and so on). Implementing a data collection plan does not necessarily mean collecting additional information. It may simply involve taking advantage of data that already exist. As such, it is important to understand the program goals when determining the necessary types of data for evaluation.

The Program Manager's Guide to Evaluation provides further emphasis for this point (U. S. Department of Health and Human Services, 2010): "when preparing to collect information (or "data") on your program, remember that any information collected can be considered evaluation data. The important thing is to identify what you would like to demonstrate about your program or practice."

Once the goals of the program are determined, it is possible to determine how to evaluate those goals. For example, if the goal of a program is to increase the use of depression screening questionnaires in elderly primary care visits, it is necessary to collect information about the characteristics of the individuals screened, the numbers of individuals screened, how they were recruited, barriers encountered in the recruitment process, and factors that facilitated recruitment. If the goal of a program is to increase the number of primary care offices that offer telemental health services, it is important to collect information on the type of services offered in primary care offices, the educational and training opportunities that exist, and the type of technical equipment available in those offices. If the goal of a program is to offer statewide crisis hotline services, it is important to collect information on the locations of individuals who use the hotline, marketing efforts for the hotline, and the number of individuals who are using the service. Once the program's goals are determined, an evaluation plan can be developed to assess whether or not the program is effectively meeting its goals.

Types of Data

Program effectiveness can be measured in terms of a process or an outcome. Process objectives and measures describe what a program is doing and how it will be accomplished. Process measures may include many aspects of the program such as participant information, planning products, activities, services, and community engagement actions. This information can help a program be accountable by meeting specific objectives (e.g., hosting a certain number of trainings, serving a certain number of people). For example, a process objective may be: By June 2012, 50 percent of rural primary care providers in the community will include a depression screening questionnaire in primary care visits. Process objectives help monitor and manage a program, and they can help keep a program on track and alert staff when things need to be changed regarding activities and strategies.

Whereas process evaluation is conducted during the program implementation phase, outcome evaluation is conducted when an objective, project, or program is completed. Outcome measures are used typically within outcome evaluation to identify the short-term and long-term results and effects of particular program activities (e.g., practices). Although outcome measures can be used to evaluate progress attained during the implementation phase, the goal of outcome evaluation is to look at the evidence of the program's effectiveness. Stated another way, outcome measures help answer the question, "What difference did the program make?" An example of an outcome measure may be: By January 2012, there will be a 25 percent decrease in the rate of suicide attempts in the community that implemented the routine depression screenings.

As an additional example of the difference between process and outcome measures, consider a community that has developed and implemented a suicide prevention program. Process components would be measured by answering the following questions in relation to the initial timeline for the prevention program:

1. How closely does implementation match the plan?

2. What types of deviation from the plan occurred?

3. What led to the deviations?

4. What effect did the deviations have on the intervention and evaluation?

5. How can the deviation(s) be corrected? Or should the deviation be corrected?

6. Who provided services (e.g., which organization, and which staff)?

7. What services were provided (e.g., treatment approach, type of disorder treated, location of treatment, and length of treatment)?

8. To whom were services provided (i.e., who is the target population)?

9. In what context were services provided (e.g., in a hospital system, or in a community)?

10. At what cost were services provided (e.g., the cost of facilities, the cost of personnel, and the cost to the consumer)?

Outcome components will further clarify data from the process evaluation using the following questions and methods:

1. What was the effect suicide prevention activities had on service capacity (e.g., increases or decreases in usage), and other system outcomes?

2. What program/contextual factors were associated with outcomes?

3. What individual factors were associated with outcomes?

4. How lasting were the effects?

Additional resources

Below are additional resources explaining the different types of data collection, as well as tools that may assist in program evaluation.

Resources

1. The Program Manager's Guide to Evaluation: http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/index.html**/**

2. Center for Disease Control Evaluation Working Group: http://www.cdc.gov/eval/index.htm

3. The Kellogg Foundation Evaluation Handbook: http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx

Tools

1. The Office of Rural Health Policy is currently working to develop a generalizable formula to help rural programs measure the impact they are making in their community. This Economic Impact Analysis Formula should be finalized and available by the end of 2010, and will be posted at http://www.raconline.org/.

2. The National Institute on Drug Abuse provides Cost Analysis Tools for substance abuse programs that may also be useful in determining a program's cost effectiveness:

   a. The Drug Abuse Treatment Cost Analysis Program (DATCAP) is a cost data collection instrument and interview guide designed to be used in a variety of health-related settings. The DATCAP helps collect and organize detailed information on resources used in service delivery and their dollar cost. The DATCAP instrument is available at the following Web site: http://datcap.com/

   b. The Services Cost Analysis Program (SASCAP) estimates the costs of substance abuse treatment services by collecting information on the resources needed by treatment programs to provide specific services and how these resource needs may differ across treatment services: http://www.rti.org/page.cfm?nav=722

   c. The Treatment Cost Analysis Tool (TCU TCAT) is a self-administered workbook designed for Financial Officers and Directors to allocate, analyze, and estimate treatment costs, as well as to forecast effects of future changes in staffing, client flow, program design, and other resources: http://www.ibr.tcu.edu/pubs/datacoll/commtrt.html - ComTreatmentCosts

Sustainability and Expansion Capacity

Based on the information gathered during the study, programs commonly had difficulty identifying consistent revenue streams to support their activities. The issue of funding is of course central to a program's ability to sustain itself and to expand. However, in relation to creating a promising practice, grant funding can be important for conducting the research needed to determine a program's effectiveness. This section therefore focuses on how to begin looking for grants and how to apply for grants once opportunities have been identified. This section will highlight some of the places to sign up for grant announcements and touch on some of the steps programs can take to develop effective applications.

Where to look for grants/signing up for announcements

Grants are generally classified according to the entity that is offering the grant opportunity. Within each entity, there may be a number of different types of grants. However, this section will focus on the general classes of Federal, State, and private Foundation funding opportunities.

Federal Grants

The primary resource for searching Federal grants is Grants.gov, a Web site listing all available grant opportunities within Federal agencies (http://www.grants.gov/). Individuals can subscribe to email notifications to receive information about various types of grant opportunities when they become available and search for current opportunities based on keywords, funding organizations, and types of grant mechanisms. Furthermore, Grants.gov offers tips on effective searching of its database and a number of resources to help applicants identify grant opportunities and technical assistance on completing Federal grant application forms. The RAC online Web site is another resource to search for available rural specific Federal grants: http://www.raconline.org/.

State Grants

To identify State grants, checking the State Health and Human Services Web site will generally provide information on currently active funding opportunities in given topic areas. State-based health foundations also vary by State, but searching the Web sites for these organizations can often lead to grant opportunities. In particular for rural communities, the State Offices of Rural Health (SORH) are not only a major partner with the ORHP, but the SORHs provide rural communities within their respective States technical assistance as well as information on available State funding opportunities and other resources (http://www.nosorh.org/).

Private Foundations

There are a number of organizations that fund rural-oriented grant applications, such as the Robert Wood Johnson Foundation and the John D. and Catherine T. MacArthur Foundation. In addition, there are some online resources for searching grant opportunities across private organizations. However, these resources may require a fee for using their services.

How to apply

Once a grant opportunity has been identified, the first step toward applying is to understand the logistics of the application by reading through the application instructions to:

1. Confirm the program is eligible to apply

2. Identify any necessary application requirements (e.g., having a Data Universal Numbering System (DUNS) number registered for the applicant organization), and

3. Determine whether the purpose of the grant fits with the purpose and goals of the behavioral health program or project.

Next, it is important to get in touch with the point of contact or project officer for the grant program listed on the application. The grant project officer is an invaluable resource throughout the application process, from advice on how to format the application text to pointing out places where the proposed ideas may be problematic from the standpoint of a reviewer.

The third step is to talk with community members and engage others whose expertise and/or services would strengthen the application (e.g., someone with program evaluation expertise at a nearby university or organization). Once everyone who will be involved in the grant application has been identified and relevant questions have been answered by the grant project officer, the final step is for program staff to start drafting the application.

Tips for effective applications

The most important characteristic of effective applications is that they have followed all the instructions completely. All relevant sections must be included, all key points must be addressed, and even the format and font of the application must meet the exact criteria specified in the grant application. Successful grants are well-written. Having others look over the application and provide feedback, particularly if they received a grant, can also help strengthen an application. Often, it is possible to receive copies of funded and non-funded applications, either by going directly to the individual whose application was (or was not) funded or by asking the funding organization to provide an example. Successful grants are typically very specific and detail every aspect of how a program will be carried out and evaluated. Talking with the grant project officer during the writing of the application can help the applicant understand the basics of the grant program and what is requested in the grant program application.

Additional resources

Many funding agencies offer grant-writing workshops to assist individuals with the grant application process. The funding agency may direct organizations to grant writing workshops or instructional opportunities. The RAC online Web site also provides some information on funding opportunities for rural organizations: http://www.raconline.org/funding/ The RAC is run by the University of North Dakota and provides resources and lists for rural specific Federal, State, and Foundation grant opportunities. In addition, RAC also has a hotline to help individuals and organizations search for specific grants and rural information in general.

Conclusions

Many rural providers have identified and implemented novel and potentially effective solutions to the accessibility, availability, and acceptability barriers to rural behavioral health care, but there is very little documentation and exchange of information as to what has worked or failed to work across rural areas. Services such as SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) exist to share information about EBPs, but these services are limited to EBPs that are not tailored to or tested in rural populations and may not generalize well to rural communities. Rural behavioral health providers lack a central resource, such as NREPP, documenting potentially promising programs

that have been implemented in rural areas across the country. In addition, there is no central resource documenting the obstacles associated with guiding programs in creating an evidence-base and a promising practice.

In this study, WICHE solicited nominations from rural programs around the country to identify programs having a positive impact on behavioral health in rural communities. The programs that responded to this solicitation were quite diverse. Each program had its own strengths, and from those strengths a set of themes emerged as indicators of a program's ability and readiness to move toward a promising practice: relevance to rural, impact on rural, sustainability and expansion capability, capacity, documentation of program information, effectiveness, and community engagement. Each of these themes is highly related to the others. For example, a program is much more sustainable with engagement from the community; a program with a clear concept of its relevance to a rural area is likely to have a high impact on the rural community it is serving; and, the measure of a program's effectiveness depends on how it is expected to impact a rural area.

The primary goal of this document is to offer a starting point to programs hoping to become a promising practice by providing additional information on each of these themes and technical assistance as to the ways in which programs can be strengthened in these areas. All programs had strengths in multiple areas, but one area in particular most programs need to strengthen is in documenting their effectiveness. Programs were highly enthusiastic about the prospect of becoming a promising practice, but a majority of programs had no data on their effectiveness. Data supporting the effectiveness of a program are the primary basis on which a program can be characterized as a promising practice. However, strengthening the other areas will also aid programs in creating a promising practice. Community engagement, program capacity, and a concrete notion of a program's relevance to rural areas not only strengthen the program's ability to collect effectiveness data, but also aid in obtaining funds for continuation or expansion, and allow other rural programs to adapt and use the program within their own respective communities.

Appendix C highlights a secondary goal of this document: To promote information exchange by cataloging novel and potentially promising behavioral health practices in rural communities and serving as a link between communities that are implementing similar programs and/or those providers who would like to set up a program similar to one described here. Many rural behavioral health providers are interested in implementing new programs in their communities. They may be unsure how to begin planning the program, securing funding, getting community buy-in, and implementing the program. By categorizing programs according to the type of service they offer and the population to which the service is targeted, this document will serve as a networking tool for rural behavioral health providers.

Although it is intended organizations will use this document to move their programs toward promising practices, one key lesson in this document is the emphasis on building connections to others in the community, particularly to researchers who can help with evaluation efforts. It is clear rural behavioral health programs with extensive community support tend to succeed and grow because improving behavioral health in rural areas is a community-wide effort. This focus on developing stronger ties to the community aids in strengthening each of the themes of robust programs, and appears to increase the likelihood of becoming a promising practice.

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Appendix A: Questions included in the Nomination Form

1.   Contact Information

1.1   Please fill in your contact information below.

Name:

Organization:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

Country:

Email Address:

Phone Number:

1.2.   What is your relationship to the program?

1.3.   At the conclusion of this project, we will develop a document summarizing the promising practices we have identified through this survey and follow-up interviews. We will also develop a technical assistance guide for promising behavioral health practices in rural areas to learn more about the strategies, methodologies, and resources needed to become evidence-based practices. Please indicate which documents you would like to receive upon project completion, if any.

☐   Promising Practices Document

☐   Technical Assistance Guide

☐   Both

☐   None

2.   Nominated Practice Characteristics

2.1.   In what type of organization is the nominated practice based (e.g., CMHC, not- for-profit)?

2.2.   What type of services does your organization provide (e.g., outpatient, residential nominated practice, psychiatric rehabilitation, prevention program, educational campaign)?

2.3.   What type of practice are you nominating (e.g., prevention, promotion, treatment, recruitment/retention, nontraditional reimbursement such as peer specialist through Medicaid)?

2.4.   What are the main services/components of the nominated practice described above?

2.5.   What is the rationale/theory for the intervention?

2.6.   How integrated is the nominated practice into the agency/community (i.e., does the nominated practice rely on services provided by another nominated practice or agency)?

2.7.   How does your nominated practice take cultural differences into account?

2.8.   What indicators of success is your nominated practice looking for (e.g., decreasing mood disorders, increasing retention of organization staff, etc.)?

2.9.   Please tell us something about your nominated practice you think is important but that we haven't asked in the questions above.

3.   Population Characteristics

3.1.   Describe the population served by the nominated practice (i.e., age, gender, race/ethnicity, etc.)

3.2.   On average, how many people does your nominated practice reach each year?

3.3.   If your nominated practice is treatment-based, what percentage of the clients you serve use public insurance (Medicaid, Medicare, or SCHIP)?

☐   10% or less

☐   11%-20%

☐   21%-30%

☐   31%-40%

☐   41%-50%

☐   51%-60%

☐   61%-70%

☐   71%-80%

☐   81%-90%

☐   91%-100%

☐   Not applicable

3.4.   What is your best estimate of the percentage of people your nominated practice reaches that live in a rural area?

☐   10% or less

☐   11%-20%

☐   21%-30%

☐   31%-40%

☐   41%-50%

☐ 51%-60%

☐ 61%-70%

☐ 71%-80%

☐ 81%-90%

☐ 91%-100%

☐ Not applicable

4. **Staff Training**

4.1.   How are staff members trained to implement new procedures in the organization?

4.2.   How are new staff members trained to implement the nominated practice?

4.3.   What opportunities do staff members have for continuing education and/or professional development (e.g., distance learning, CMEs, etc.)?

4.4.   How is staff evaluated on procedural compliance to organizational policy?

4.5.   How is staff evaluated on procedural compliance to the nominated practice?

4.6.   How is staff performance tracked and recorded?

4.7.   Is staff co-located with other programs?

4.8.   What educational backgrounds do key staff members have?

5. **Documented Nominated Practice Information**

5.1.   What is the mission of the nominated practice? Please indicate if your mission is formalized in a mission statement.

5.2.   Do you have a policy/procedure manual that guides your organization?

☐ No

☐ Yes

If yes, please briefly describe the format and content of the manual or other related document.

5.3.   Do you have a policy/procedure manual that guides your implementation of the nominated practice?

☐ No

☐ Yes

If yes, please briefly describe the format and content of the manual or other related document.

5.4. Are there brochures or materials that provide information about the services and nominated practice offered by your organization?

☐ No

☐ Yes

If yes, please briefly describe the format and content of any brochures, materials, or other related documents.

5.5. Do you have any grants your nominated practice has applied for or received?

☐ No

☐ Yes

If yes, please briefly describe the grants (i.e., funding organization, purpose, etc.).

5.6. Do you have a document that describes your nominated practice (treatment/intervention), either formally or informally?

☐ No

☐ Yes

If yes, please briefly describe the format and content of the document.

6. Data Collection/Research Capacity

6.1. Does your nominated practice collect data in any form?

☐ No

☐ Yes

If yes, what kind of data do you collect (e.g., demographic, outcomes)?

6.2. If your nominated practice does collect data in any form, how are the data collected (e.g., electronic records, treatment notes)?

6.3. Describe the evidence you have that your nominated practice has a positive outcome for the population you serve.

6.4. How do you make sure your nominated practice is implemented consistently?

6.5. Is there someone in the nominated practice who works on evaluation, and/or have you ever worked with an evaluator?

☐ No

☐ Yes

If yes, please describe the evaluation experience.

6.6. Is there an evaluation plan to measure the effectiveness of your nominated practice?

☐   No

☐   Yes

If yes, please summarize the evaluation plan.

7.   Additional Information

7.1. If you have any additional information you would like us to know about your nominated practice, please include that information here.

7.2. Please let us know if you have any additional comments and/or concerns about the survey.

Appendix B: Phone Interview Follow-Up Questions

1. Summarize the program/practice you are nominating.

2. Describe the roles of the main staff involved in the practice.

3. What are you doing that is unique?

4. In what ways is your program having an impact in rural areas?

5. What benefits is the program having for the people you are serving (e.g., patients keeping appointments, staying on medications)?

6. How is your program funded?

7. What evidence do you have that your program is sustainable?

8. Aside from funding, what kind of support is needed to continue or expand the program?

9. What kind of support is needed to evaluate the program?

10. How easy would it be to replicate your program in another State/community?

11. How did you hear about this nomination process?

Appendix C: Description of Rural Behavioral Health Programs

Overview

The list of programs represented in this appendix is by no means comprehensive or exhaustive. The programs described here are limited to those who responded to the initial survey asking individuals to nominate programs for inclusion in this project. Few programs had the resources to collect and analyze effectiveness data. In the absence of data, there are no criteria to determine the characteristics that make one program more promising or effective than another. One solution to this problem would be to develop a set of criteria for ranking the programs that is not based on effectiveness data, but the sheer diversity of programs being implemented in rural areas makes this task impossible. Communities nominated programs ranging from crisis hotlines to integrated care centers to professional training programs, and no one set of criteria can be applied to determine whether, for example, a hotline is a more effective rural behavioral health program than an integrated care center without overlooking many potentially innovative and effective programs. Therefore, the purpose of this appendix is not to rank programs in terms of their effectiveness, but to promote information exchange among rural providers who are finding novel and innovative solutions to the substantial barriers to providing behavioral health services in rural areas, by documenting the programs that participated in this project.

Organization of Program Descriptions (by categories, highlighted program, summaries and strengths/weaknesses of others)

The program descriptions throughout this appendix are organized according to the category into which the program best fit (integrated care, outreach, etc.). Each program that completed a phone interview is mentioned, with a brief description of the program, as well as its perceived strengths and weaknesses. Programs that received site visits are described in more detail than other programs within each category, to provide an example of how the seven themes, described above, can be applied to a rural program to identify areas to target for improvement.

Adapting EBPs for Rural Areas

Idaho Region 7 rural ACT Team

Summary of Practice

The Idaho Region 7 rural Assertive Community Treatment (ACT) Team provides mental health treatment to a mental health court. The program focuses on recovery, in order to get mental health court clients to the point that they will no longer need ACT services and can maintain their lives outside of the justice system with less intense services. Individuals with a felony or misdemeanor charge who use the ACT Team services fall within the medium to high range of severity of mental illnesses (e.g., schizophrenia), often have a dual diagnosis of substance abuse or dependency, typically have had frequent incarcerations in the past, and have a history of criminal behavior. The rural ACT Team reaches approximately 25 individuals each year.

The use of ACT Teams to provide mental health services is an evidenced based treatment model, but the research is still inconclusive as to the effectiveness of ACT Teams with reducing recidivism in the corrections system and reducing jail time, as well as using smaller teams that do not by themselves meet the ACT standards. The Idaho Region 7 rural ACT Team has a physician's assistant, access to nurses, and a social worker, who plays an active role in visiting all individuals seen by the team (often visiting up to 7 individuals in their homes each day). Sometimes the teams also include a probation officer, a peer, or others with specific skills when needed. With support from a larger ACT Team 30 miles away, the Idaho Region 7 rural ACT Team is demonstrating their program to be as effective in treating mental health problems as full ACT Teams.

The Team sets up a weekly meeting schedule for participants, including dual diagnosis groups, decision-making groups, Moral Reconation Therapy (MRT), and free time planning. Almost all individuals participating in the ACT Team through the mental health court are employed, and are able to maintain their employment for the first time in years.

Themes

Rural Specificity (Relevance)

Idaho has few mental health services available for anyone living outside of its larger cities. The rural ACT Team makes use of these scarce resources to adapt and bring evidence-based treatments to Idaho's residents.

Impact

1. **Availability -** The rural ACT Team makes services available to residents who otherwise would not have a chance of receiving evidence-based treatments.

2. **Accessibility -** The program focuses heavily on visiting participants in-home, which decreases problems with accessing remote services.

3. **Acceptability -** The rural ACT Team is educating the justice system about mental health issues, making the provision of mental health and substance use services more acceptable for everyone involved in the program.

Sustainability/Expansion

The mental health courts are funded by the Idaho State Legislature, and the rural ACT Teams also receive State funding. As long as the State continues to perceive good effects of the rural ACT Teams, the program is highly sustainable. There is currently room for 10 ACT participants in the mental health courts, although the ACT Teams operate outside of the courts as well, reaching approximately 25 people per year.

Population Targeted Training

The collaboration between the justice and mental health and substance use systems leads to a high degree of informal education between these two systems. Probation officers and other law enforcement officials learn about mental health and substance use issues and treatment, and social workers and health professionals learn about the problems their clients typically run into with the law and can identify ways to redirect them.

Program Documentation

The rural ACT Team and its clients are guided by a mental health court client handbook, the ACT standards, and the National Association of Social Workers (NASW) code of ethics to follow. There is also a brochure discussing the ACT Team services.

Collection and Use of Data (Effectiveness)

The rural ACT Team looks for the consumers to be able to graduate from mental health court. Other measures of success are that consumers have stable and sustainable housing, they can manage a budget, they understand their illness and know how to recognize symptoms and have a wellness recovery action plan. Additional measures of success include a decrease in hospitalizations and/or jail days, and for clients with dual diagnoses to stay clean and sober.

The Team also collects demographic information, discharge reasons and jail and hospital days. The mental health court does enter data into the State database, however the rural ACT Team does not have access to this data directly. The probation officers and the court coordinator do have access to the data in the State system. The data the court coordinator has provided indicate that individuals in the mental health court who use the rural ACT Team show a 97 percent reduction in hospitalizations and an 87 percent reduction in jail days. There has been a graduation rate of approximately 50 percent, and a recidivism rate of approximately 20 percent among graduates, indicating that 40 percent of individuals who go through the rural ACT/mental health court program are graduating and staying out of the justice system.

Community Engagement

The Idaho 7 rural ACT Team requires a high level of engagement from the justice system, as well as social, health care, mental health, and substance use services. For example, if a problem arises with a participant, social workers and probation officers are able to work together to identify a problem and a solution, rather than being sent back to court or placed in jail. Everyone involved in the program speaks to its effectiveness on improving rural ACT participants' abilities to function without engaging the justice system, and shows a high degree of dedication for the program and its participants.

Strengths

The dedication and community engagement of the rural ACT Team are real strengths for the program, and ensure its success. Without the engagement and buy-in from numerous State and local systems, the program would not be possible in a rural region with scarce mental health and substance use resources.

Areas for Growth

The rural ACT Team and mental health courts collect useful data, but do not have the resources to analyze it. Having an evaluator available would potentially allow the team to expand its service reach by providing evidence of cost savings to the State (which funds the programs).

Center for Children, Inc. (La Plata, MD)

The Center for Children, Inc. is a private, non-profit mental health clinic providing therapeutic services to individuals, adults, and families. The Center for Children has adapted Functional Family Therapy (FFT) to its service area, enabling FFT to be provided across three counties in southern Maryland. To enable FFT to work in its community, Center for Children staff travel to homes of clients, and assign a case management person to the therapy team. This case manager works with schools to track school attendance and academic performance and to connect the family with needed resources. The Center for Children is certified as a FFT site, which means there is a FFT supervisor on site who can communicate with the FFT national program, and train replacement staff in the FFT program in-house. The program collects a range of data, and has found over 80 percent of children who work with the FFT program show improvement in attendance and suspension rates.

Josephine County Community Corrections (Grants Pass, OR)

Josephine County Community Corrections provides Continuum of Care Services in an outpatient setting for substance-abusing offenders on supervised probation or parole. The services provided are all evidence-based (e.g., Moral Reconation Therapy, Breaking Barriers, Matrix curriculum). The program has been very successful in receiving grants to train staff in evidence-based practices, and provides staff with 40 hours of training each year to assist in bringing additional EBPs to the program. The program is unique in having clear and measurable outcomes and goals for its use of EBPs: reducing recidivism rates, successful completion of parole or probation, and maintaining abstinence from all mood-altering substances. With these goals in mind, the program has proven successful, with a recidivism rate 16 percent lower than the rest of the county, and 19 percent lower than the State.

North East Program Evaluation Center (West Haven, CT)

The North East Program Evaluation Center is guiding the implementation of the Rural Access Network for Growth Enhancement (RANGE) programs, an adaptation of the Mental Health Intensive Case Management program for rural areas. The RANGE program is based on the Assertive Community Treatment model, and provides psychosocial rehabilitation services to persons with severe and persistent mental illness who are living in rural areas. These services include community-based case management, psychotherapy, assistance with housing, vocational support, education and support to family or non-family caregivers, and substance use treatment. There are 19 teams operating throughout the country, with a social worker and nurse practitioner on each team. Some teams have additional staff, such as a homeless coordinator. The teams are based at the U. S. Department of Veterans Affairs Medical Center (VA), with some teams working out of Community Based Outcomes Clinics (CBOCs), but all teams are intimately familiar with their respective communities given the extensive outreach they do upon formation of the team (to group homes, primary care providers, and other places in the community where veterans are served). The program collects data on patient characteristics to evaluate its effectiveness, including services received, treatment, and outcomes assessment.

Community Education and Outreach

Northwest Arctic Borough

Summary of Practice

The Youth Leaders Program empowers students to feel responsible for what occurs in their schools and in their villages. Project staff, along with students, has developed a behavioral management technique that follows traditional teachings and is extremely effective. This area has the highest incidents of suicide and other societal ills in the State of Alaska. Most students - including those involved in the Youth Leaders program - have overcome personal tragedies. With the Youth Leaders program, schools are reporting greater than 90 percent success rates with behavioral and suicidal interventions.

Student leaders are chosen anonymously by their peers. Each high school and 8th grade student gets to write down the name of whom they would go to if they had a problem; the leaders are chosen from these "nominations." There are five student leaders per school, with one of those the captain of 11 schools. All leaders, except for one who is a middle school student, are high school students.

If a child is having a behavior issue, the school leaders will take that child out of class into another room without an adult and talk with him/her. That child cannot talk, but has to listen. After five minutes, the child is escorted back to his/her classroom. They have only had one or two 'repeat offenders.' The high school leaders also teach a counseling curriculum to the younger kids. The student leaders are highly engaged in their school communities, supervising after-school suspension in some schools, holding pep rallies, having luncheons for elders, and sponsoring sports tournaments. Each school site has incentives (such as play time on a Wii) for perfect attendance, and other demonstrations of good behavior.

Themes

Rural Specificity (Relevance)

There is such a high turnover rate of teachers and other community leaders in this area - the only consistent people are the kids. The culture is different from what non-Alaska Native people are used to, and people without an Alaska Native background do not appropriately meet the needs of the students. Having the student leaders take over brings success to the culture and the community. The students fill the void in lack of resources in many ways that are specific to their native, rural culture. Further, every school is given a laptop and any student can chat with a counselor or youth leader as needed.

Impact

1. **Availability - m**The peer support program is increasing the availability of support to Alaska Native youth by providing culturally appropriate behavioral health resources that would otherwise not exist for the youth at these schools.

2. **Accessibility -** Services are provided in school, making them highly accessible to youth in these remote areas.

3. **Acceptability -** The cultural appropriateness of the Youth Leaders program increases the acceptability of the support the Youth Leaders provide. In addition, having Youth Leaders in the schools enhances the students' acceptance of behavioral health issues and increases their willingness to seek help from their peers.

Sustainability/Expansion

The program currently has Federal funding, but programs in other school districts have proven to be self-sustaining, leading to a high likelihood that this program will become self-sustaining as well. The students fund-raise for camps and other activities that they participate in, and the high degree of community support for this program suggests the project will be financially supported once Federal funding has ended.

Population Targeted Training

Staff members, administrators, and board members are introduced to the program and the new student leaders at the beginning of each year. Throughout the year, students are involved in advertising how the program works through activities and presentations. Site administrators (usually the school principal) train new staff members and endorses the use of the students in classrooms and throughout the school year in a variety of activities.

Program Documentation

The mission statement; purpose and history of the program; guidelines for participants, school administrators, counselors and teachers; activities guidelines; retreat training manual; youth leadership training manual; and other guidelines are included in the Youth Leaders operation manual. Colorful brochures that briefly explain the program are targeted to collaborative agencies, parents, and school staff.

Collection and Use of Data (Effectiveness)

Electronic, verbal and hard copies of surveys and disciplinary referrals are collected. School disciplinary referrals have decreased and behavioral health referrals have increased since the program began.

Community Engagement

In addition to general community support and endorsement of the project, the Youth Leaders Program also has support and partnership from additional community organizations that offer counseling and support to youth in the Borough.

Overall Comments/Additional Observations

While peer mentoring/leadership practices have a difficult time showing success in the Lower 48 States, this program has already shown great improvement and positive results.

Cascades East Area Health Education Center (AHEC) (Bend, OR)

The Cascades East AHEC hosts a 3-day, regional conference focused on mental health topics for primary care providers, mental health professionals, and other allied health providers in rural areas (the Regional Biennial Educational Conference on Mental Health and Primary Care). The conference offers continuing education credits, and attracts a growing number of individuals from Oregon and surrounding States (the Fall 2008 conference had 170 registrants). A particularly unique feature of the conference is its reliance on attendees to drive program content: The AHEC collects needs assessment data from attendees to inform the planning process and ensure providers' needs are met by the content of each conference. The conference connects rural providers to others in similar communities, providing a chance for individuals across the State to learn from each other's experiences. In addition, by focusing on providers' educational needs and bringing in regional experts, the conference is able to provide education and tools to rural providers who would not otherwise have access to cutting edge research and treatments.

Center for Children, Inc. (La Plata, MD)

The Center for Children, Inc. is a private, non-profit mental health clinic providing therapeutic services to individuals, adults, and families. The Healthy Families Program provides support for at risk teen parents. The Healthy Families Program set up a collaborative agreement with local hospitals in which all new, teen mothers are screened for risk of child abuse. The program supports and educates teen mothers after they leave the hospital, beginning with a family assessment to find out what type of information the families want, and ending when the children are in school. The program teaches new mothers about low-cost developmental games to play with children, as well as basic information on caring for babies, such as sleeping habits, signs of illnesses, immunization schedules, breastfeeding, child-rearing practices, and developmentally appropriate activities. The program also provides much-needed support to mothers, setting up activities and get-togethers for the parents (moms and dads), assisting with obtaining daycare vouchers so the parents can stay in school, educating fathers about the need to stay engaged in their children's lives, and encouraging mothers to stay in regular high school. Parents in the Healthy Families Program have an increased graduation rate, with 100 percent of mothers employed or having graduated from high school, and 98 percent without any reported child abuse. By identifying a need in the community, and developing a program with clear goals and measures of success, the Center for Children has excelled in bringing a much-needed prevention program to its community.

ETSU Office of Rural Community Health Partnerships (Johnson City, TN)

The Office of Rural Community Health Partnerships at Eastern Tennessee State University began providing small grants to its communities to address the issue of substance abuse in the region. The program began by inviting area counties to attend a 3-day conference involving skill-building sessions for various stakeholders from each county (public health, law enforcement, health care professionals). Each county came up with a plan to combat a local problem related to methamphetamine use, including long-term and short-term goals, strategies, and action plans. The counties used small grants from the Office of Rural Community Health Partnerships to develop diverse, community-specific programs such as emergency responder kits for children found in homes with methamphetamine laboratories, training for employers and employees in recognizing signs of methamphetamine use and its effects in the workplace, and community-wide drug awareness and prevention efforts (some of which have grown into their own organizations since the initial grant from ETSU). The small grant program through ETSU has helped counties build confidence in their ability to deal with drug problems in their communities, and helped build coalitions across various stakeholders in each community. Although the grants were very small to begin with, many communities were able to use the seed money to grow substantial substance abuse programs in a very short period of time. Collecting information on the type of projects or partnerships that were sustainable would help ensure future small grant efforts are used effectively.

Great Lakes Inter-Tribal Council, Inc. (Lac du Flambeau, WI)

The Honoring Our Children project through the Great Lakes Inter-Tribal Council uses an intervention approach to work with pregnant and inter-conceptional women and their children from birth to 2 years of age. The program provides case management, health education, inter-conceptional care, maternal mental health screenings and referral, and support services such as phone usage and transportation. The program operates at seven different sites in rural northern Wisconsin, and is delivered differently at each site, depending on the needs of the project site. An incentive program called Wadiswan-Ojibwe for Nest offers supplies such as blankets, diapers, baby clothes, and nursing bras for accomplishing goals of the program (e.g., breastfeeding for one year, keeping medical appointments). A unique feature of the Honoring Our Children project is its reliance on trust-building within communities and with individual families to gain access to mothers and families in these severely underserved tribes. The program is able to open the door to intervention, education, and care programs that change individuals' behaviors to improve children's health.

Project ACCESS (Moscow, ID)

Project ACCESS provides community outreach and education, professional education and networking, and prevention programs. The project supports increased access to mental health care for seniors through efforts such as recruiting volunteer drivers in rural communities, implementing caregiver support groups, and purchasing mental health related books and DVDs for local libraries. The program works to educate area professionals on senior mental health issues and has created a network of community stakeholders to identify gaps in mental health services and education in the region. The program is unique in its ability to cross county and State boundaries to deliver these services to seniors. Three area hospitals are involved in Project ACCESS, as well as regional geriatric advocacy groups. Each of the main Project ACCESS initiatives has been funded through Federal grants. This collaboration between diverse agencies is central to the program's success in receiving funding, as well as in using that funding to affect the lives of seniors in the project area.

Yukon Kuskokwim Health Corporation (Bethel, AK)

The Family Spirit Project run by the Yukon Kuskokwim Health Corporation is a prevention, awareness, parenting education, and rural outreach program that serves three Alaska Native villages each year. The program engages community members by identifying needs, issues, and concerns of each village, and preparing a multi-day gathering to address these issues. Follow-up on the gatherings includes continued support for accessing regional resources. The primary goal of the program is to have individual villages develop ongoing wellness teams that would hold gatherings on their own to address the villages' needs and concerns. The program is developing an evaluation plan, but initial reports from participants suggest communities show increased readiness for change following the gatherings.

Court Teams

Coos County Infant/Toddler Court Team

Summary of Practice

The Coos County Infant/Toddler Court Team is a prevention program that provides core services to maltreated infants and toddlers ages 0-3 years and their caregivers. The goals of the program are to increase positive outcomes for maltreated infants and toddlers, decrease the reoccurrence of abuse/neglect, decrease the time spent in foster care, and change the court's culture to focus on children's needs.

The team has adapted a research-based model for their program, maintaining critical components of the model such as caseworker consistency (1 caseworker throughout the entire program, for the parents and child), having the child stay with a single foster family, frequent parental visitation (with high concern for the child's safety), and concurrent planning (having an alternate plan that can be moved to quickly if the child is in danger).

To accomplish the goals of the program, the Court Team includes an infant/child psychotherapist, a public health nurse or aide to teach parenting and child development, CASA representation, drug and alcohol or mental health treatment for the parent(s) (if warranted), a caseworker in Child Welfare, a nurse for the child if the child has special needs, attorneys for the child and each parent, and a judge. Each case is staffed through monthly meetings with the judge and team members, and includes monitoring the family's progress in meeting the goals set at previous meetings.

Themes

Rural Specificity (Relevance)

All of the children and families served by the Court Team are from rural areas, and a big emphasis of the program is to bring services to the families whenever possible. This includes providing transportation for the parents to get to classes and therapy, emphasizing home visits and housing that bring parents closer to services, bringing families to the family centers, and closely coordinating services through the team to minimize travel burdens.

Impact

1. **Availability -** The Court Team makes intensive, wraparound services available to residents who otherwise would not have access to those services, however, the main impact for rural communities is in their efforts to ensure accessibility for participating families.

2. **Accessibility -** As noted above, the Court Team has a major emphasis on bringing services to families, and assisting families as they access services. The close monitoring and communication between Team and family members ensures these intensive services are accessible to rural children and families.

3. **Acceptability -** Not applicable.

Sustainability/Expansion

The Team currently has resources for a maximum of 5 families, but is seeking funding to double their capacity by funding a full-time Team Coordinator. The fact that each agency currently donates their staff member's time to the Court Team makes the program highly sustainable on a smaller scale, but external funding is necessary to extend the Team's capacity.

Population Targeted Training

The team provides trainings for the community and for all agencies involved with very young children on topics such as the attachment needs of infants and toddlers, the developmental milestones that must be achieved to place children on a path to future physical and emotional health, and how to repair relationships in young, traumatized children. Attendees for these trainings have come from throughout the State of Oregon, and the larger Northwest region.

Program Documentation

Parents in the program receive a family manual which describes information such as the court team, stage phases of the program, court etiquette, mental and physical health services, parenting requirements, and the goals of the team. There are additional written policies and procedures that govern issues such as confidentiality in each agency, and these are coordinated by the agency leaders and the Team coordinator.

In addition, the Team has a brochure entitled "Coos County Zero to Three Court Program: Babies Can't Wait." The brochure outlines services to families, program eligibility, the purpose and goals of the program, and court and community partners.

Collection and Use Of Data (Effectiveness)

The program currently looks for the following markers of success: no re-entry into the foster care system for the children; parents who remain sober, off of probation, employed, and on any necessary medications; and consistent well-child visits and vaccination schedules. Evaluation forms are sent to families to evaluate their experience with the Team and are sent out quarterly after graduation. The Team Coordinator compiles the data. Although the program is still relatively new and takes a year to complete, the team has graduated one family, and two mothers have graduated without the fathers. Unfortunately it is difficult to track the families, as they have moved out of the area, and if they move out of State, it becomes impossible to determine whether the families have re-entered the system.

Community Engagement

The success of the Court Team depends largely on community engagement from a wide range of team members. The team involves court representatives, a judge, child development specialists and advocates, mental health and substance use professionals, and health professionals. Partnering agencies currently donate the time of these individuals to the Team. This high degree of community engagement and collaboration enables the Team to fully support the children and families involved, and give them the best possible chance of staying together.

Strengths

The particular strength of the Infant/Toddler Court Team is the commitment and collaboration between Team members. The intensive support to family members, and the coordination of services among team members who are spread across Coos County, is a major factor in the success of the program.

Areas for Growth

The main area of growth for the Team is to expand its capacity, through external funding for both staff time and training (e.g., training more individuals in infant/child psychotherapy). This effort could be facilitated by providing cost-effectiveness data for the Court Team services, and/or finding a means to track families who have graduated from the program even if they leave the area.

Crisis Services

Hill Country Crisis Stabilization Unit

Summary of Practice

The Crisis Stabilization Unit at Hill Country Community Mental Health Mental Retardation Center (Hill Country MHMR) is a 16-bed inpatient unit that provides acute care services to adults in psychiatric crisis. It was opened in April of 2009 in its own building located on the grounds of the Kerrville State Hospital. The larger Hill Country MHMR system, of which it is a part, provides Mental Health, Mental Retardation, Early Childhood Intervention and Substance Abuse Services through a 19 county, 22,000 square mile area of the greater Texas Hill Country. The population base for the area is over 560,000. The Crisis Stabilization Unit was developed after the Kerrville State Hospital was closed to civil commitments and began accepting only forensic commitments. When this occurred, all civil commitments in the Hill Country MHMR were diverted to other parts of the state. Hill Country is the only MHMR Center in Texas that has a Crisis Stabilization Unit. The Unit provides services for adults who have a mental illness such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution. Services are provided in accordance with the recovery based Resiliency and Disease Management model of care. This model incorporates disease management, psychiatric rehabilitation, wellness strategies, and training in self-management. Services include clinical coordination, medical services, pharmacological management, psychiatric rehabilitation, psychotherapy (Cognitive Behavioral Therapy), supported employment, supported housing, and peer support. Services are designed to build on the strengths of the individual and to focus on outcomes on their road to recovery.

The Crisis Stabilization Unit integrates inpatient and outpatient community mental health services by working in tandem with the local mental health clinics. Recovery based discharge planning begins immediately upon admission to the crisis stabilization unit and incorporates outpatient clinic staff throughout the discharge planning process. Collaboration with CMHCs occurs regularly through video conferencing. Inpatient services are recovery based and utilize services such as psychiatric rehabilitation and connection with peer support in order to compliment future outpatient services and develop a comprehensive seamless system of behavioral health services.

Themes
Rural Specificity

The Texas Hill Country is a predominantly rural area and the Hill Country MHMR system serves a nearly 100 percent rural population. The outpatient mental health services in the system serve 5,780 adults annually. Based on an average 7 day stay and 80 percent occupancy, the Crisis Stabilization Unit is anticipated to serve 667 individuals from this rural population on an annual basis.

Impact

1. **Availability -** Not Applicable.

2. **Accessibility -** The Crisis Stabilization Unit largely improves access to treatment for individuals in the Texas Hill Country who are experiencing a psychiatric crisis by allowing them to receive these services within their own community. Prior to the development of this Unit, these individuals were sent to hospitals in other parts of the State, and were hours away from their families and communities. The use of telehealth technologies between the Unit and the community outpatient MHMR centers ensures that outpatient services and supports are received subsequent to inpatient treatment in order to maintain access to care and stabilization of symptoms.

3. **Acceptability -** The unit addresses issues of acceptability and stigma by encouraging family and community involvement in individual recovery.

Sustainability/Expansion

The Unit was funded by Texas Department of State Health Services providing funding based upon hospital bed days for 16 State hospital beds. Other funding includes local funds from the County, private funds from foundations, a State grant, a Federal grant (Texas Infrastructure Fund), and Federal reimbursement for treating Medicaid patients. Hill Country's Crisis Stabilization Unit is one of the first programs in over a decade that is funded by moving bed days from the State hospital system into the community setting. Most inpatient psychiatric beds in Texas are within the State hospital system. Demonstrating the effectiveness of the integration of inpatient and outpatient services using a community setting could encourage further movement to small psychiatric inpatient facilities within the community behavioral health system.

Population Targeted Training

Every member of the staff at the Crisis Stabilization Unit has had psychological rehabilitation training. They are certified by the University of Chicago in this regard. The University sent trainers and provided a compressed, 2 week course in order to train the staff in psych rehab. The staff uses an objective fidelity tool as well as treatment plan and chart checks and competency checks to ensure fidelity to the program. The peer support specialists are also provided a condensed version of the psych rehab training.

Program Documentation

The Crisis Stabilization Unit's policy manual contains detailed policies regarding client's rights, medical records, documentation, and administrative procedures. The manual is divided into sections based on the individual service. The Psych Rehab training manual provides guidance around use of this specific model of care. The program also has a tri-fold brochure for each program which gives a summary of services provided, location of service, and contact information.

Collection and Use of Data

The program collects demographic information including but not limited to address, gender, income, ethnicity, employment status and housing status. This data is collected through treatment plans, progress notes, and Texas Recommended Authorization Guidelines. All services recorded in the computer system are mapped to DSHS encounter codes and electronically transferred to the department. Data regarding assessments is also entered into the information system and includes diagnostic information as well as assessment measures regarding the following dimensions: Functioning, Housing Instability, Employment, Criminal Justice, and Co-occurring Substance Use. The Unit also tracks patient outcomes via individual treatment goals and recidivism rates. At the time of this interview, data had not yet been collected but was expected to be available beginning in November 2009.

Community Engagement

The peer support services at the Unit are facilitated by members of the community who are mental health care consumers. The Unit was partially funded by local funds and was furnished using money raised in the local community.

Strengths

The unit helps reduce recidivism by focusing on recovery. Thus far, there has been no recidivism in program. Another wonderful strength of this program is their peer support services. The peer support groups are facilitated by past patients and provided on the Unit. The peers are very impressive in their recovery and commitment to helping others recover. Hill Country is working toward making Peer Support a billable service.

Hotlines

Sowing the Seeds of Hope (Agriwellness, Inc.)

Summary of Practice

The Sowing the Seeds of Hope (SSoH) program, administered by AgriWellness, Inc., provides affordable, acceptable, and culturally appropriate behavioral health assistance to underserved and at-risk persons engaged in agriculture and their families in a seven State region that encompasses Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota and Wisconsin.

Each of the seven States operates a telephone helpline/website geared to agricultural callers and is able to offer information and referral for additional forms of necessary assistance such as legal advice and referral for follow-up behavioral health counseling. The counseling is provided by professionals trained in agricultural behavioral health and is available free of charge when necessary through a voucher system. The program also provides outreach, community education, social marketing, and advocacy.

Each State has a coalition of committed organizations, individuals and agencies that help maintain statewide farm crisis helplines and services. Some States also offer educational retreats for farm individuals and families, support groups for agricultural people and home visits to individuals who are homebound. On behalf of the seven-State network, AgriWellness undertakes training of providers in agricultural behavioral health, provides technical assistance and fund-raising for the network and carries out evaluation of the region-wide services, research and advocacy.

Themes

Rural Specificity (Relevance)

Agricultural workers are a special population at high-risk for mental health and substance use problems, existing largely in rural, underserved areas. Realizing there is a severe shortage of behavioral health professionals in these underserved areas, the program empowers agricultural workers to manage their own behavioral health as much as possible by providing behavior management skills to the agricultural population in language and concepts that are understandable to this special, high-risk population, and is able to send them to culturally-competent providers for treatment when necessary.

Impact

1. **Availability -** Not only do the helplines and websites increase the availability of behavioral health support for the target population, but the agricultural behavioral training provided to all helpline responders as well as area behavioral health professionals ensures culturally appropriate services are available to agricultural workers throughout the seven-State region.

2. **Accessibility -** The confidential, telephone-based helplines are available 24 hours each day, seven days each week, ensuring constant access to services for those in need. In addition, these services are free, and vouchers exist for those who seek services from area providers. The hotline has staff members who are either fluent in the languages common throughout each State's agricultural workers, or has constant access to translators to ensure everyone who accesses the services is able to make use of them.

3. **Acceptability -** By making support services available and accessible for agricultural workers, the SSoH program is breaking down the barriers to acceptability among agricultural workers. Training behavioral health providers in agricultural behavioral health further enhances the acceptability of services, because those who seek behavioral health services are given culturally appropriate treatment.

Sustainability/Expansion

Designed and initiated by the Wisconsin Office of Rural Health and Bureau of Primary Health are in 1999, the Sowing the Seeds of Hope network sought and obtained grants from the Federal Office of Rural Health Policy (ORHP) for three successive years. When it became clear that a region-wide administrative agent was needed, the SSoH partners selected AgriWellness, a nonprofit corporation located in a rural setting, Harlan, IA, to provide administrative functions. This took place in 2001. Since then AgriWellness and its State partners successively obtained a Network Outreach Grant from the ORHP for the years 2003-2006. In 2006 a Compassion Capital Fund grant was obtained to improve the network capacity building, particularly revenue development strategies. Subsequently, AgriWellness and its partners obtained a Rural Health Network Development grant, for the years 2007-2010. AgriWellness and its partners have also obtained Congressional Directed Funding grants in 2002, 2003, 2004, 2007 and 2008. The Congressional Directed Funding for the past two years was for the State of Wisconsin only.

The program was successful in attracting several private foundation grants (e.g., Farm Foundation, Land-O-Lakes Foundation, Otto Bremer Foundation) for specific region-wide and State projects. AgriWellness has sought and successfully obtained private and Federal funds to assist with its biannual conference, "The Clock is Ticking for Rural America: A Behavioral and Safety Conference."

AgriWellness often has successfully sought contracts from the Iowa Department of Human Services to manage crisis counseling programs following major disasters, such as tornadoes, floods and Hurricane Katrina, which contributed to the migration of more than 2,000 persons into Iowa from Louisiana, Mississippi and Texas. AgriWellness staff frequently provide consultation and speaking services for a fee, which is used to help maintain the headquarters and to help pay administrative staff. AgriWellness has successfully sought grants from the Great Plains Center for Agricultural Health for research and information dissemination projects. Currently AgriWellness has applied for research funds to undertake a comprehensive evaluation of the farm crisis program services. Pilot funds have been awarded. Agriwellness has a full research proposal and is seeking additional support to compare States that provide farm crisis behavioral health supports with States that do not offer such assistance to their respective agricultural populations. AgriWellness also has sought and obtained several grants to help develop the first textbook and curriculum on agricultural behavioral health, to train primary care providers (i.e., family physicians, internists, physician assistants and nurse practitioners), behavioral health care providers (i.e., psychologists, psychiatrists, social workers, counselors, addiction counselors, marriage and family therapists, nurse practitioners and licensed professional counselors), and allied service providers (e.g., pastors, paraprofessional outreach workers and Extension employees).

Generally, each of the seven States that comprise the SSoH network obtains funds to operate its telephone hotline/helpline and website from a combination of State supports (e.g., State appropriations) and private funds (e.g., church collections, contributions, private foundation grants). AgriWellness has assisted with the major burden of obtaining funds to pay for follow-up professional behavioral health care services, research, training, service coordination and technical assistance. This blend of Federal, State and private resources has enabled the program to survive through difficult economic times. Now the Farm and Ranch Stress Assistance Network, which has been authorized by the U.S. Congress as part of the Food, Conservation and Energy Act of 2008 (i.e., the Farm Bill) will provide funds to continue the essential behavioral health supports for the agricultural population in the SSoH region and two other parts of the country. The current Congress is considering a request for appropriated funds to operate this authorized program.

Population Targeted Training
The Sowing the Seeds of Hope program was founded on the premise that sharing tools, expertise and best practices among the seven State partners would improve behavioral health supports for agricultural people throughout the region. Sharing these best practices takes place in a number of forms. The Board of Directors meet face-to-face at least twice yearly to conduct strategic planning, network development and to undertake training. AgriWellness sponsors a three-day conference every two years, entitled "The Clock is Ticking for Rural America: A Behavioral Health and Safety Conference." The Board of Directors confer in monthly telephone conference calls and more often as necessary.

AgriWellness employs a training/research director, Mr. Jim Meek, who has many years' experience as a special programs manager for the Iowa State University Extension. The AgriWellness executive director, Dr. Michael Rosmann, is a former professor of psychology at the University of Virginia and currently is an adjunct associate professor in the College of Public Health at the University of Iowa. Dr. Rosmann, Mr. Meek and other consultants provide many workshops to the AgriWellness partners and their staffs that operate the State programs and to the providers of behavioral health services in the seven States. All the Board members, coalition members and persons who are interested in improving behavioral health care of the agricultural population receive a monthly newsletter, AgriWellness Partners. The AgriWellness staff share scholarly articles and training materials with all the State partners and coalition members.

Program Documentation
AgriWellness has a SSoH manual, in both electronic and hard copy versions, which contains coalition information, program service assessments, goals and gaps in services for each State. Each State partner has a signed master agreement with AgriWellness which stipulates the expectations for the partners and AgriWellness and specific contracts for each grant that is administered by AgriWellness on behalf of the State partners. In addition, AgriWellness has a standardized SSoH reporting form which is used by the SSoH State partners when they compile their service data. The State partners submit the data to AgriWellness on a semi-annual basis. AgriWellness maintains the SSoH Access database.

AgriWellness provides a number of brochures about its programs and services that describe the SSoH network. Each State partner maintains a set of brochures and publicity materials such as refrigerator magnets and business cards. AgriWellness maintains a website, two monthly newsletters that are distributed electronically to approximately 13,000 recipients and links with all the State partner websites. Program information was distributed in several States to all county Extension offices and all county Farm Service Agency offices.

Collection and Use of Data (Effectiveness)
Since its inception in 2001, AgriWellness, Inc. has employed the services of an independent evaluator to conduct an independent evaluation of the overall program and whether it is meeting its stated objectives. AgriWellness and its seven State partners have adopted a standardized data reporting form, definitions and objectives. The indicators of success include data that reflect the numbers and types of users of all SSoH services, evaluations of provider training, and evaluations of professional services completed by clients. The evaluation methods preserve the confidentiality of all clients and have been approved by an Institutional Review Board.

AgriWellness received a pilot grant from the Great Plains Center for Agricultural Health to initiate a comprehensive evaluation of its services to determine if the telephone helplines and additional behavioral health supports deter suicide among members of the agricultural population in states that offer the SSoH services in comparison to states outside the region that do not offer such specialized services. The pilot portion of the project has been completed. A research committee that includes the independent evaluator, three AgriWellness staff members and two consultants who are affiliated with the Iowa State University, are applying for Federal funds to complete the comprehensive evaluation.

Indications from the pilot research are that the agricultural population finds the telephone helplines/websites accessible and appropriate for their needs. During the period from November 1, 2005 – October 31, 2007, 43,852 persons contacted the seven State helplines. The helplines distributed vouchers for professional behavioral health services, 79 percent of which were redeemed for 7,238 sessions of professional behavioral health assistance. The program trained 1,369 professional providers, offered community education to 7,515 participants and reached 760 persons in educational retreats.

Regional Reach and Span
The program encompasses a 7-State region, nearly 15 percent of the United States. All agricultural workers within participating states have access to the SSoH services.

Community Engagement
The seven State partners provide follow-up professional services through selected licensed mental health and addiction counselors who have at least some familiarity with agriculture and training in agricultural behavioral health and who are contracted to provide services at a discounted rate, much like an Employee Assistance Plan. This involvement of local providers and resources within a larger regional program gives the program the community support it needs to be successful and reach its target population.

Strengths
One of the biggest strengths of the SSoH program is its sheer size and span, and the organization and collaboration that make this large reach possible. The participating states all recognize and support the need for available, accessible, and acceptable services to the agricultural community, and the expertise of Agriwellness staff in not only the topic area (agricultural behavioral health), but also grant writing, funding, and data collection/evaluation create an unusual and exceptional combination of experience to support and sustain the SSoH program.

Integrated Care

Behavioral Health Services of the Shenandoah Valley Medical System

Summary of Practice

Behavioral Health Services of the Shenandoah Valley Medical System is a co-located behavioral health program within a community-based Federally Qualified Health Center (FQHC) providing primary care services. The Behavioral Health Services (BHS) department provides psychological consultation, diagnostic assessment, psychopharmacological consultation and management, intensive outpatient services for substance use, and individual/group therapy. It also includes a migrant service outreach team that travels to rural areas and provides clinics as well as transportation for migrant workers to come into the primary care clinic for services. Also included is a Women, Infants, and Children team that travels into rural counties and provides transportation to the clinic for services.

A portion of the BHS department is the Primary Behavioral Health (PBH) service, which provides consultation services. A member of the BHS department staffs the PBH service at all times. All patients seen in primary care receive a general behavioral health screener at least once each year that includes affective disturbances and substance abuse. All new moms also receive post-partum screenings. All scores are reviewed by the medical provider. Any screener that results in a score above the cutoff is followed up on by an on-the-spot behavioral health consultation. Any other potential behavioral health issue that is picked up on by the provider but missed by the screener is also followed by a behavioral health consultation. One-hundred percent of these identified patients are seen for consultation. If further assessment or treatment is warranted, the PBH provider registers the patient with the BHS department and they are seen for follow-up in the same building. The PBH provider also provides consultation to the medical provider regarding the patient. About half of patients who receive consultation become regular BHS patients. It usually takes about 2 weeks to be seen for regular therapy. Patients with severe need can be seen right away in medical treatment rooms. If a patient is in crisis, the BHS team can send them to the inpatient facility 2 blocks away. The BHS team can also put patients on mental health holds.

Themes

Rural Specificity (Relevance)

The migrant worker outreach and WIC outreach programs provide identification of need and access to services for the rural population that would otherwise have no way to obtain them.

Impact

1. **Availability -** As mentioned above, the migrant worker and WIC outreach programs bring services to areas where they would not be available otherwise.

2. **Accessibility -** This Behavioral Health program has continued to provide in excess of 20,000 treatment encounters per year, increasing accessibility of services to all people who visit the clinic.

3. **Acceptability -** These programs address issues of acceptability and stigma by bringing the services directly to the individuals who need them, without requiring that they seek them out themselves. Creating access in this way also helps to normalize the receipt of services in these areas.

Sustainability/ Expansion

The PBH consultation service is funded at 1 FTE, and is staffed by 14 different staff members for 4 hour blocks of time with 1 staff on the consultation service at a time. This FTE is funded by a Federal block grant that is provided to FQHCs and is renewable. As long as the center keeps its FQHC status, this funding will continue. Additionally, because Medicare and Medicaid reimburse behavioral health services in West Virginia, the consultation time is often reimbursable. When it is not, it is rolled into the block grant. When patients are seen regularly at the BHS department, insurance is billed or the patient is offered a sliding scale payment schedule. The Director of the program believes that any FQHC could replicate the consultation practice quite easily.

Population Targeted Training

Through a partnership with West Virginia University, medical and social work students have clinical placements in the Behavioral Health Program, enhancing the training of students by giving them hands-on experience in a co-location FQHC.

Program Documentation

The Behavioral Health Program has specific policies and procedures that guide the practice to include assessment of patients, order of the medical record, screening tools, discontinuance of care, and more. In addition, brochures describe services available and list clinicians who provide various programming like "Substance Abuse Intensive Outpatient Program" and the general BHS Clinic services.

Collection and Use Of Data (Effectiveness)

The program collects much of its data via Electronic Medical Records, which are accessible by providers across disciplines. Data collected by Electronic Medical Records includes demographic, individual patient outcomes, numbers of patients referred, follow-up, where they are seen, reason for treatment, and specific medication data. The center also collects patient safety compliance and quality improvement data.

Community Engagement

The Behavioral Health Program provides employee assistance services to several local companies including City Hospital and QuadGraphics plant. As noted above, BHS is a collaborative partner with West Virginia University and the Rural Health Education Partnership. Medical students and social work students also have clinical placements at this program.

Strengths

The clinic has a "if it's your patient, it's our patient" mentality. The medical and behavioral health providers communicate regularly about shared patients through notes in the EMR and verbal feedback. Additionally, medical providers can attend the twice-weekly BHS team meetings in order to facilitate communication. They frequently attend in order to present specific cases as well as to discuss general behavioral health issues. The physical set-up of this practice makes it uniquely effective, because the BHS department is in the same building and patients do not need to be referred out for services. All the services are provided by Board Certified or eligible Professionals. The program has maintained the highest standards of Behavioral Health Care by being accredited by The Joint Commission.

Areas for Growth

Provider outcomes are not currently being measured in the program, but would be beneficial for further growth.

Adapt, Inc. (Roseburg, OR)

This program employs a single Licensed Clinical Social Worker (LCSW) as a Behavioral Health Consultant in four primary health care clinics. Patients coming in for a health visit use an electronic tablet to fill out a screener for mental health problems (the Quick PsychoDiagnostic screen). Those with scores above the cutoff are seen immediately or scheduled for consultation by the LCSW. Particular strengths of the program include their successful use of grant funding to purchase the electronic tablets for screening, and their use of a volunteer Master's of Public Health student at a nearby university for evaluation services. The student is currently using demographic and outcome data to evaluate the success and reach of the program. One area of improvement for the program is in finding a way around some of the access issues confronting its rural community, such as needing to reschedule patients on a subsequent day for follow-up due to Medicare billing restrictions on the number of services allowed in a single day.

Adventist Health (Roseville, CA)

Adventist Health provides a number of outpatient behavioral health programs in its rural health clinic. The clinic is owned and operated by the local hospital, and includes psychiatry, therapeutic counseling, ADHD evaluation, biofeedback, and group therapy in addition to its primary care, dental, and specialty services. The clinic is especially proactive in increasing access to behavioral health care for its rural residents. The clinic provides in-home services when necessary, and is working with the county mental health department to ensure patients not meeting criteria for services can be referred to the clinic for general and crisis services.

CareSouth Carolina Behavioral Health Department (Hartsville, SC)

CareSouth Carolina provides outpatient mental health and substance abuse treatment services in a co-located primary care and behavioral health center. Along with being co-located in the same building and floor, the program is fully integrated, with behavioral health and primary care providers sharing a single patient chart, as well as screening all primary care patients for depression using the Patient Health Questionnaire (PHQ), and handing off patients with positive screens immediately to the behavioral health provider. The program also focuses heavily on recruiting its own staff to become behavioral health professionals, providing time off and encouraging staff with sufficient interest to return to school for a master's in clinical social work. Aside from its exceptional recruiting strategy, the program is also highly results-oriented, and uses the PHQ to track depression outcomes and reduce disparities by looking at outcomes on a monthly basis. For example, after finding a 15 percent disparity in depression improvement by race, CareSouth Carolina was able to identify and ameliorate the factors leading to different outcomes, and successfully eliminate the disparity. The program works closely and meets frequently with other groups in the community, such as the hospital, alcohol and drug programs, homeless shelters, Community Mental Health Centers, and the Department of Social Services.

Cherokee Health Systems (Knoxville, TN)

Cherokee Health Systems is a non-profit, Community Mental Health Center (CMHC), as well as a Federally-Qualified Health Center (FQHC). Cherokee Health Systems has a truly integrated, biopsychosocial approach to health care, and aims to address the whole person by integrating behavioral health services into primary care. At Cherokee Health Systems, behavioral health consultants are embedded members of the primary care team, providing real-time assessments, brief interventions with patients, and consultation with providers. The behavioral health consultants provide education, behavioral management, and intervention services for behavioral health and medical conditions. The director of psychiatry consults with primary care providers, rather than carrying his own caseload, and is able to do this consultation from off-site via video conference. The health history questionnaire used during routine visits has questions relating to depression, anxiety, and substance abuse. The program is also reaching out to rural providers by serving as a training site for behavioral health professionals to gain hands-on experience in the integrated health model.

Munroe-Meyer Institute: Outreach Behavioral Health Clinics (Omaha, NE)

The Outreach Behavioral Health Clinics program provides outpatient behavioral health services to children, adolescents, and families across the State of Nebraska in primary care settings. There are 12 integrated clinics throughout the State, as well as five clinics that collaborate with the program. Faculty and staff provide outpatient services in the same locations as patients receive their primary care, and physicians are provided with weekly updates on their patients. In addition to offering behavioral health services in rural clinics, the program trains students in providing behavioral health care in rural settings. Graduate trainees from the University of Nebraska work side-by-side with faculty members in the clinics, beginning with observation, and later taking an active role in treatment. The university and community partnerships that have been built by the Munroe-Meyer Institute have led to a growing and successful program that is increasing the accessibility of behavioral health care in rural areas. The Outreach Behavioral Health Clinics are an exceptional example of academic researchers partnering with frontline providers to provide behavioral health services to rural Nebraskans.

Salina Regional Health Center Behavioral Health Services (Salina, KS)

Behavioral Health Services physicians provide acute inpatient, intensive day, and outpatient services to individuals with behavioral health needs within the larger setting of Salina Regional Health Center. The program employs physicians to see outpatients, perform consultations in the hospital, provide inpatient care, as well as supervise Physician Assistants and Nurse Practitioners. Employing physicians allows for 24/7 call access to psychiatrists, which is available to anyone who calls within the region. Psychiatrists also travel to outlying family practitioners for behavioral health consultations, providing a safety net for rural family practitioners. Behavioral Health Services is exceptionally adept at adapting to the needs of its rural community, particularly with regard to its veterans. In response to having the premier combat division in the nation within its service area, the program set up a clinic through a community partnership with Fort Riley to increase access to soldiers with behavioral health needs.

Sierra Family Medical Clinic (Nevada City, CA)

Sierra Family Medical Clinic is a non-profit community clinic located in rural Northern California. The clinic provides outpatient behavioral health services that are co-located and fully integrated with primary care and dental services. The key feature of their integrated care service is that all medical and dental patients are screened for depression and/or mental illness. If a patient's screening warrants referral, a health care provider personally escorts the patient to behavioral health services (termed, "Lifestyle Management"), where they either have a brief conversation with a behavioral health provider and set up an appointment, or are seen immediately. If an additional assessment is needed, telepsychiatry is used to connect the patient with a psychiatrist on-site, who initiates medical therapy and then returns the individual to the primary care provider for management. The other services provided on-site by behavioral health staff include crisis intervention, behavior modification (including smoking cessation), substance abuse, improved dental hygiene, relaxation therapy, and weight loss.

Southwest Virginia Community Health Systems (Bristol, VA)

Southwest Virginia Community Health Systems is a primary care and behavioral health integrative service. The program uses a collaborative care model, with each clinic having three to five primary care providers, and one to two behavioral health clinicians. Primary care screening tools are used to identify behavioral health issues. Primary care providers and behavioral health clinicians use a single medical chart and provide brief behavioral health care, such as stress reduction for chronic illnesses, as well as behavioral treatment. All individuals with identified chronic illnesses see the behavioral health clinician, and there is a strong focus on helping individuals understand the relationship between behavioral health and chronic illnesses.

Peer Support

Montana Warm Line

Summary of Practice

The Montana Warm Line is phone- and web-based prevention, health promotion, and support service. The Montana Warm Line consists largely of a toll free peer support hotline for Montanans dealing with mental illness in their lives. It employs 15 peer supporters, who each work from their own homes. Peers on the Warm

Line receive 16 hours of training, including topics such as active listening, suicide, referrals, values, boundaries, culture, role playing, and the Wellness Recovery Action Plan (WRAP).

The Warm Line is specifically designed to reach those people living in rural settings with few to no services available, those with limited mobility, and those who desire a higher degree of anonymity while seeking support for mental illness. Over half of callers are in treatment of some sort but are often unable to get appointments when they need them, and turn to the Warm Line as a way of holding them over until their next appointment. In addition, the program offers a weekly telephone-based bipolar support group, informational website with blog, and soon will include telephone-based informational seminars and open chat groups.

In addition to providing services to people, this program is an excellent way for consumers to help each other. It uses peer-to-peer principles and provides a rewarding and empowering job opportunity for consumers living anywhere in the State. The Warm Line is an invaluable resource for Montana, which still battles high rates of stigma surrounding behavioral health.

Themes

Rural specificity and relevance

Most communities in Montana are too small to sustain a physical behavioral health drop in center. Eighty percent of Montana communities have fewer than 3,000 residents, 19 Montana counties do not have a behavioral health provider, and nine counties have no private medical services at all. The Montana Warm Line virtual phone and internet-based drop-in center services reach the more than 16,000 adults in rural and frontier areas who have serious psychological distress, as well as those who live in the more remote parts of relatively populous counties.

Impact

1. **Availability -** The Warm Line makes peer support services available to many Montanans who are not able to see providers due to extremely low availability of behavioral health providers in the State. As noted above, many callers to the Warm Line are in treatment, but that treatment is not always available with the frequency it is needed.

2. **Accessibility -** The Warm Line provides easy access to supportive peers. The Warm Line allows people to reach out for support, information, and resources without ever leaving their home. This is beneficial not only to those people in rural areas, but also to people with limited mobility, those who lack transportation, and those who prefer a degree of anonymity. Warm Line services are free, so access is not limited by an individual's ability to pay.

3. **Acceptability -** The Warm Line addresses the issue of acceptability because it is a confidential and allows people to access peer supports without any concern that others in their communities will know they are using behavioral health services. Also, the marketing for the Warm Line helps normalize behavioral health problems across the State.

Sustainability/Expansion

The Warm Line is funded through a State drop-in center grant. Although there is not a physical drop-in site, the Warm Line serves as a virtual drop-in center. The program is working toward moving into a volunteer organization, which would increase the sustainability of the program.

Population Targeted Training

Warm Line responders receive continual training, through monthly group phone meetings where they can call in and learn about behavioral health issues in Montana (e.g., domestic violence).

Program Documentation

Marketing materials for the Warm Line include brochures, posters, magnets, wallet cards, and pens. Brochures provide an overview of services provided by the Montana Warm Line, as well as contact information for both the Warm Line and Mental Health America of Montana. Posters, magnets, and wallet cards provide a brief description of the Warm Line and the contact information. Pens have the Warm Line name and phone number on them.

Collection and use of data (Effectiveness)

The Montana Warm Line tracks the number of calls on the hotline; website hits; number of participants in support groups; gender, age, and location; emotions/feelings presented; reason for calling; diagnosis or treatments; and referrals given. The Warm Line is currently developing an evaluation plan to track additional information, such as the caller's response (whether they feel supported, listened to, etc.), utilization of services, the perceived utility of the bipolar support group, and the behavioral health of the responders.

Regional Reach/Span

Warm Line callers and responders are spread across the nearly 150,000 square miles in the State of Montana.

Community Engagement

The Montana Warm Line provides resource referrals to services all across the State. In addition, they have partnered with a local Licensed Certified Professional Counselor to facilitate the Bipolar Support Group, and are working on developing a statewide resource guide for responders.

Strengths

The Warm Line provides peer-based behavioral health support services to Montanans who might otherwise end up using crisis or emergency services. In a State with large geographical barriers to treatment, the Warm Line enables consumers to find scarce behavioral health resources in their communities, as well as to bolster their treatment by providing another person to talk with in-between sessions, or when their behavioral health provider may not be available.

Areas for Growth

The Warm Line is working to develop an evaluation plan, but has not yet achieved that goal. In addition, the Warm Line would have a better chance of sustaining itself if it could find a way to rely more heavily on non-renewable grant funding, or by using volunteers rather than paid consumers, which they are moving toward.

Appalachian Consulting Group (Cleveland, GA)

Appalachian Consulting Group is a for-profit training and consulting corporation that uses a network of national consultants to help provide training and support for states to implement Medicaid-billable peer support services. The group provides a 5-day training for Certified Peer Specialists (CPS) to assist mental health consumers with recovery in the State of Georgia. The goal of the CPS program is to support secondary relapse prevention and promote wellness by using the Relaxation Response to reduce stress and anxiety. The CPS program recently partnered with the Institute for Mind Body Medicine at Massachusetts General Hospital to demonstrate the effectiveness of the peer-taught Relaxation Response. In a pilot study, the CPS/Relaxation Response program was successful in decreasing overall stress and anxiety among peers supported by CPSs.

The Main Link (Towanda, PA)

The Main Link provides non-clinical, consumer-run services that offer peer support, recreation, education, advocacy, and linkages with mental health services for mental health consumers in two rural counties. Peer support services include adult and youth drop-in, art studio, education, and outreach programs. The program has extraordinary reach into the community, through extensive marketing and successful grant-writing efforts, and individuals are referred to the program through local businesses as well as provider agencies. To increase access to its services, the Main Link provides transportation vouchers to ride the bus to the centers, and has purchased vans to travel to members and transport members to activities. The program provides mobile and outreach activities to county residents who are not able to come to the centers, such as those being treated in the State Hospital. To further engage the community, the Main Link holds an annual anti-stigma fair in the downtown area, featuring artwork and information about mental illnesses.

Recovery Innovations (Phoenix, AZ)

Recovery Innovations provides peer training and support to enable individuals with lived experience of recovery to assist others who are undergoing treatment. Peer Support Specialists are given 80 hours of training, which enables them to be a part of the treatment team. Peer Support Specialists are working in crisis programs, housing programs, educational programs, and also engage in hospital work. Recovery Innovations has held peer trainings in 32 states, as well as the United Kingdom and New Zealand. Staff is also trained in how to work with peers, with particular emphasis on the role of peers in recovery. Peer Support Specialists are trained to develop relationships with clients, in order to facilitate their treatment. The peer training model used by Recovery Innovations has grown substantially, and the organization now employs 200-300 Peer Support Specialists. The biggest barrier to expanding the program is creating jobs and opportunities to hire peers. However, the program has been creative in finding ways to encourage employment opportunities, such as by providing financial incentives to employers to hire peers.

Special Populations

New Hope Behavioral Health Unit (Corry Memorial Hospital)

Summary of Practice

The New Hope Behavioral Health Unit at Corry Memorial Hospital is an inpatient treatment center for geriatric patients who are a danger to themselves or others. Corry Memorial Hospital is a critical access hospital, which has a unique collaboration with other regional hospitals to provide behavioral health services to inpatients in its Behavioral Health Unit. All area hospitals contract with a single group of behavioral health professionals (through Deerfield Behavioral Health), which provides psychiatrists for treating the patients in the Behavioral Health Unit, but which also provides social workers who conduct free, in-home behavioral health assessments for community residents.

Geriatric community members referred by family members, doctors, or nursing home staff are assessed in-home by Tri-State Elder Assessment Management (TEAM) social workers. Individuals who screen positive for depression, dementia, or other mental illnesses and require hospitalization are admitted to the Behavioral Health Unit, where they spend at least two weeks receiving inpatient treatment. The treatment team in the Behavioral Health Unit includes a psychiatrist (who is a contracted employee), a social worker, nurses, and behavioral health technicians, who all provide a highly structured schedule of individual treatment and group activities such as music, hands on crafts, and baking. A social worker in the Behavioral Health Unit assists with discharge and arrangement of care and outpatient services for patients who are ready to leave the Behavioral Health Unit.

Because the Behavioral Health Unit is located in a hospital setting, patients have access to a range of health professionals that may be important to their recovery, including a family practitioner who is assigned to each inpatient and sees the patients within 24 hours of their arrival in the Behavioral Health Unit, dieticians, physical and occupational therapists, and speech therapists. A contract between Corry Memorial Hospital and Deerfield Behavioral Health ensures one of the 9 psychiatrists at Deerfield Behavioral Health, are in the Behavioral Health Unit to see and monitor patients every day, including weekends and holidays.

Themes
Rural Specificity (Relevance)
The Behavioral Health Unit has a 50-75 mile service radius covering the rural, tri-state area of Northwestern Pennsylvania, Chautauqua County in Southwestern New York, and Ashtabula County in Northeastern Ohio. The New Hope Behavioral Health Unit is the only behavioral health unit in the State, and one of a few behavioral health units in the country.

Impact
1. **Availability -** The Behavioral Health Unit sees their impact on availability to rural residents as the most important service provided. They provide the only geriatric inpatient services in the area, and their unique relationship with Deerfield Behavioral Health increases the availability of behavioral health services to the elderly community throughout their service area. The psychiatrists at Deerfield also noted the benefits of their arrangement to their ability to retain and recruit behavioral health professionals to the area, therefore ensuring continued availability of service providers. Rather than existing in isolation at individual hospitals, the nearly one dozen behavioral health providers at Deerfield are able to rely on each other for support and professional development.

2. **Accessibility -** The TEAM responds by phone to requests for behavioral health assessments within one business hour and does the behavioral health assessments on-site within 48 hours. The unique relationship of the TEAM as contractors through Deerfield Behavioral Health ensures the TEAM social workers see people on evenings and weekends, consulting with Deerfield psychiatrists to determine the best course of action for each individual assessment. The TEAM social workers put together health histories to enable patients to get started with treatment as soon as they walk in the door of the Behavioral Health Unit. Due to the unique arrangement between Corry Memorial Hospital and Deerfield Behavioral Health, the TEAM assessments are free to community members.

3. **Acceptability -** The Behavioral Health Unit, in partnership with TEAM and the Deerfield Behavioral Health staff members do in-service trainings in the community, for senior centers, nursing homes, and other community stakeholder groups. These trainings, conducted as often as three times per month, focus on behavioral issues of interest to each group, and help to reduce the stigma surrounding behavioral health problems in the elderly population.

Sustainability/Expansion
The New Hope Behavioral Health Unit is a highly sustainable program with a Medicare patient base, as well as patients who self-pay or have private insurance. The hospital provides all additional funding for the Behavioral Health Unit, including the funding for the contracted psychiatrists at Deerfield Behavioral Health, and all in-home assessments conducted by the social workers (who receive per diem reimbursements for site visits). The Behavioral Health Unit does not rely on external funding, and hopes to expand to include slightly younger patients (not adolescents) in the near future.

Population Targeted Training

The Behavioral Health Unit attends and hosts community health fairs specifically for behavioral health issues in geriatric populations, and frequently offers free depression screens at these fairs. They share information about the unit at nursing homes and provide information regarding mental illnesses specific to the elderly for community groups. These trainings not only help decrease stigma, but also allow individuals to get to know the doctors in their communities, and allow the doctors to serve patients and consumers without a "doctor's hat". These trainings are particularly effective because the doctors are not tied to a hospital but are contracted employees. Their goal is to inform the consumer, and to divert patients from inpatient services, rather than fill hospital beds.

Program Documentation

The Behavioral Health Unit and the TEAM have brochures describing their services. These brochures are distributed throughout the community, at locations such as health fairs, senior centers, and the local high school.

Collection and Use Of Data (Effectiveness)

The goal of the Behavioral Health Unit is to generate improvement in quality of life, including general and behavioral health. Family members of patients treated in the unit say the service is very necessary and is helping substantially. They are happy with the program, and particularly with their ability to be a part of the treatment process, given the emphasis the unit staff place on working with family members and making relevant contacts in the community. The unit provides a questionnaire that goes home with patients, but it is very general and is not easy to get data back from the questionnaires, especially for patients who are returned to nursing homes. The Behavioral Health Unit staff noted there is a need for a quantitative person to design a formal questionnaire and then analyze the results.

Community Engagement

The TEAM program was developed a few years ago by combining the initial patient evaluation, assessment, and marketing process between Corry Memorial Hospital and other facilities within 50-60 miles providing inpatient services. The relationship between area hospitals and Deerfield Behavioral Health Services is older, and began more than a decade ago when area hospitals recognized the need for an independent group of behavioral health providers with which to contract.

Community partnerships with senior centers, nursing homes, and community clubs enable speakers to address a range of topics and ensure a wide range of education programs for the community. These community partnerships were developed via phone calls to stakeholders, in-person visits, and a good relationship with the State hospital. The Behavioral Health Unit and its partners not only provide a valuable service to the community through their assessment and inpatient services, but also work to change area communities to make them more aware of how to care for elderly behavioral health issues, and identify ways the unit can better support the community.

Strengths

The particular strength of the Behavioral Health Unit is Corry Memorial Hospital's relationship with Deerfield Behavioral Health and the cooperation of the hospital with other regional facilities. The commitment of the hospitals involved ensures there is no reliance on outside funding, and their hiring of dedicated staff provide the best possible treatment for patients admitted to the unit (the unit has a seclusion room, but has never used it). Being in a hospital setting, patients in the Behavioral Health Unit have integrated care, including behavioral health professionals, primary care providers, and a range of therapists.

Areas for Growth

The main area of improvement for the Behavioral Health Unit, as noted with many of the other practices, is a lack of data and program evaluation. The staff simply does not have support to collect and analyze data related to the program's success, although the longevity of the unit (10+ years) attests to its ability to sustain itself.

Overall Comments/Additional Observations

This program offers a valuable service for geriatric residents in the rural area covered by the Behavioral Health Unit. The unique and innovative relationship and partnership with area hospitals to provide in-home assessments and behavioral health professionals to the community is truly innovative and should serve as a model for other rural communities.

Pride Manchester House

Summary of Practice

Pride Manchester House is a residential psychiatric treatment facility in the State of North Dakota that exclusively serves young children ages 5-13 years who demonstrate serious emotional disturbances. Offering clinical, educational and residential services, Pride Manchester House is the cornerstone program in the State that serves children under 10. Its onsite classroom is staffed and provided by the local school district. Pride Manchester House offers assessment-based options for short-term placements. The facility has eight beds for residential treatment.

Pride Manchester's approach to continuum of care includes pre-admission and diversion services, assessment services, residential services, clinical services, educational services, transition and aftercare services, and out of State diversion.

Children are referred to Pride Manchester house in a variety of ways, including from the community, child protective services, and family members. Once the staff at Pride Manchester receives a referral, they send a team, consisting of at least a team leader and a case manager, to interview the child, family, school and any community members involved in the child's life. If residential care is appropriate, the child is placed on a waiting list until a bed is available. Until the child comes to Pride Manchester House, he/she and family members are visited regularly by the team to begin the counseling process. Frequently, community resources are put in place at this time for the child and family members. Once the child arrives at Pride Manchester House, the average stay is around six months. This length is dependent upon the severity of their situation, home life, community resources, and so forth. The child and family is continually seen after he/she leaves Pride Manchester House for up to one year.

Themes

Rural Specificity (Relevance)

North Dakota has 53 rural counties and four Native American reservations, with limited access to behavioral health services. Geographical barriers exist which preclude families from receiving intensive therapeutic services for youth with severe behavioral health needs. Statewide outreach services prior to and after residential care allow for responsive on site assessment and provision of services. By providing these services to children and families, a therapeutic relationship and rapport is established prior to residential treatment, and continued after until the children and families feel supported within their communities.

Impact

1. **Availability -** The biggest barrier to care addressed by Pride Manchester House is the availability of behavioral health services for children, particularly the outreach services component. By utilizing outreach services, professional staff have already met and assessed the child's required level of care, based on both the written referral and direct interaction with the child, the family and the child's support in their community. Investing in outreach provides services statewide without increasing institutional costs. Parental, custodial, and agency feedback regarding outreach is consistently positive, citing availability, responsiveness, partnering with community services, and support and providing highly individualized care for the child, family and school personnel.

2. **Accessibility -** Not applicable.

3. **Acceptability -** Not applicable.

Sustainability/Expansion

Since 2003 this program has been funded through private donations and fund-raising activities. One such fund-raising activity occurred this year for the program's anniversary with the theme, "It's All About the Children!" Eight fiberglass statues of children were given to area artists who volunteered to transform them into unique expressions of childhood hopes and dreams. The online auction for these statues occurred in September 2009, with all proceeds used to enhance children's services at Pride Manchester House.

Population Targeted Training

Pride, Inc., which is the parent company of Pride Manchester House, welcomes community volunteers and has a training schedule listed on their web site offering courses for the community such as CPR and Youth Mentoring.

Program Documentation

The policy and procedure manual for Pride Manchester House describes the organization and its policies, as well as policies for program-specific information such as referrals, admission, discharge and aftercare. Brochures describing the program as well as outreach include information such as the mission statement, program overview, hallmarks of care, referral process, outcome statistics, and cost. A one-page summary describes the program's philosophy and continuum of care.

Collection and Use Of Data (Effectiveness)

Outreach data are collected electronically to track numbers and types of contacts per child, time spent, travel time, and content of contact. Written documentation is used for the transition matrix, admission and discharge minutes, monthly staffing reports, satisfaction surveys, and treatment notes. A formal written report is prepared to finalize an assessment of a child. Thus far, the use of data has supported the continuation of program components through financial and other support and increasing FTEs where needed.

When the outreach program first started, 40 percent of referrals were successfully maintained in a less restrictive level of care. In 2008, 60 percent of the referrals for placement at Pride Manchester were diverted, so children were able to successfully remain in their homes with outpatient services and supports in their home community. Additionally, Pride Manchester has established a post-discharge success rate of 96 percent annually, due in large part to the aftercare support of the outreach program.

Community Engagement

The program relies heavily on collaboration with schools, hospitals, community providers, churches, volunteers, social services, juvenile services and other public and private agencies. This collaboration comes in large part through volunteers: community members volunteer their time as a Big Brother/Big Sister, churches invite kids for fun nights and other church activities, and community members volunteer to visit Pride Manchester House during holidays. No other residential facility in North Dakota provides this service – over the past 10 years, the program has grown and evolved into a fully collaborative model of care. After outreach with Pride Manchester House is completed, the child's community resources and supports are solidified and self sustaining.

Strengths

The strengths and innovativeness of the Pride Manchester House is most certainly the outreach component. This includes both pre and post treatment services. With the addition of outreach services (preadmission and aftercare), the average length of stay has decreased to 6 months. The outreach program has played a significant role in providing smoother transitions into and out of the treatment program. Each year, children are successfully diverted from placement in a residential program due to community intervention by Pride Manchester's outreach team. In the last three years, 109 children were diverted from placement. At discharge, aftercare services provide ongoing support and services to children and their families. Eighty-eight to 96 percent of residents remain in a less restrictive level of care for 12 months post-discharge due to the continuity and consultation provided by outreach.

Areas for Growth

The program would like to move toward collecting longer-term follow-up as well as more specific data regarding the components of treatment that were effective.

Overall Comments/Additional Observations

Pride Manchester House was selected an as "exemplary program" by Project REACH of the U.S. Office of Special Education. Pride Manchester was recognized for its "innovative and exemplary program and practices for serving children with intensive social, emotional and behavior needs". Pride Manchester House is nationally accredited through the Council on Accreditation.

Cumberland Mountain Community Services (Cedar Bluff, VA)

Cumberland Mountain Community Services provides comprehensive public behavioral health care. The Regional Deaf Services Program (RDSP) provides outpatient services to persons who are deaf, hard of hearing, or deaf-blind. Treatment services in the RDSP, including therapy, psychiatric evaluation, medication clinic, case management, crisis services, and behavioral health support services, are provided by sign language fluent clinicians. The focus on recruiting and retaining sign language fluent clinicians is truly unique, particularly for a rural service provider. Cumberland Mountain Community Services utilizes teleconferencing with an off-site psychiatrist fluent in sign language to provide psychiatric services to their deaf, hard of hearing, and deaf-blind clients. The program has grown from serving five deaf individuals to serving more than 35 active cases. The RDSP's particular strength is in finding ways to meet the needs of its rural community through recruitment and retention of culturally-appropriate staff, and using telemedicine to bring in expertise they do not house on-site.

Four County Mental Health Center (Independence, KS)

Four County Mental Health Center is a community mental health center located in rural southeast Kansas. Four County developed the Senior Outreach Services (SOS) program as a component of their outpatient mental health department. The goal of SOS is to provide outreach, assessment, treatment, and case management services to older adults, age 60 and above. The SOS program brings a mental health professional to individuals' homes and the community to decrease the financial, structural, and personal barriers that keep people from seeking behavioral health services. In addition to providing care to seniors, the program provides education for community agencies that serve seniors to facilitate early identification and treatment. One of the strongest features of the SOS program is its role in building connections between stakeholders in the community to address issues important to seniors in rural southeast Kansas. They are also collecting data on the program's effectiveness, through a grant from the Office of Rural Health Policy, and working with an off-site evaluator to analyze the data. The program has found that after six months, 94 percent of older adults receiving treatment from SOS were able to remain in the community rather than move to an extended care facility.

McCann Treatment Center (Bethel, AK)

McCann Treatment Center is a 14-bed, Tribal, residential treatment program for boys ages 10-18 with mental health and substance use problems. The program provides mental health and substance use treatment, with a cultural focus on the traditional Yupik calendar. Program participants engage in traditional activities such as commercial and subsistence fishing, fish processing, camping, berry picking, gardening, sport fishing, game processing, wood gathering, and plant and animal identification. In addition, the McCann Treatment Center typically incorporates a Native elder counselor, who assists in the classroom, leads groups, and helps with clients in crisis. By incorporating these culturally-appropriate skills into the treatment program, young men are able to learn alternatives to substance abuse, as well as healthy life and coping skills. The culturally-specific program has shown to be successful, based on contact with former clients and families, as well as the Office of Children's Services and the Department of Juvenile Justice.

Vera French Community Health Center (Davenport, IA)

The School-Based Mental Health Services provided by the Vera French Community Health Center provides mental health treatment to elementary-age children in the school setting by licensed mental health practitioners. Play therapy, family therapy, and parent-child interaction therapy are also used. Each participating school provides space for a therapy room, with supplies provided by Vera French. The program also works with schools and families by providing consultation and collaboration with parents and school staff, mental health education for school staff, and linkages to other community resources as needed. To measure student progress, the program developed a reliable and valid measure of therapeutic outcomes (the Crucial C's Assessments), which measure four qualities considered to be assets for children: connect, courage, count, capable. Parents, students, and teachers all contribute to this measurement tool. Using this measure, the program has demonstrated significant improvement among students receiving treatment.

Telemental Health

Oklahoma Department of Mental Health and Substance Abuse Services

Summary of Practice

The Oklahoma Department of Mental Health and Substance Abuse Services has implemented a Statewide Telehealth Network using real-time videoconferencing to provide mental health and substance abuse services throughout Oklahoma. Telehealth services are utilized by Community Mental Health Centers, courthouses, hospitals, clinics, and State penitentiaries. In addition, the State now uses this system to conduct State meetings, employee trainings, personnel investigations, and more.

The development of this network was based upon the results of a needs assessment conducted by the State, which found significant geographical barriers to access to care, especially in rural Oklahoma. The network was originally piloted in one Community Mental Health Center (CMHC). The CMHC was able to serve 180 extra people during the 3 month pilot. The patient receives services in a satellite clinic that is local to them, while the provider is located at one of the larger, primary CMHC sites. Each CMHC has 5 or 6 satellite offices in rural communities. Next, the system was piloted at a courthouse and installed in the judge's chambers. This system increased efficiency by making it unnecessary for police to transport individuals from the jail to the courthouse for hearings. The telecourt services are now being used in four counties. The next pilot of the system was as a jail diversion program in the State penitentiaries. The pilot focused on reducing the gap in care for people with mental illnesses who are being released from jail. At the time of this interview, no data had been collected on this pilot.

Themes

Rural Specificity

The end goal for the system is for every person in Oklahoma to be able to access services within 30 minutes of their home. Oklahoma has many communities have no psychiatrist or other specialists. This service provides access to mental health and substance abuse services to all people and specialty services (e.g. child psychiatry) that might otherwise be unattainable.

Impact

1. **Availability -** The State of Oklahoma contracts with hospitals to provide psychiatry services through the telehealth network so that individuals may have appointments with these professionals without leaving their communities. This network improves the availability of services because, as is the case in many areas, many specialists are in short supply in Oklahoma. This system allows specialists such as child psychiatrists to be available to more individuals in more communities. Additionally, telecourt services free up police officers in rural counties who might otherwise have to spend much of their time transporting people in for hearings, allowing for rural police officers to stay within their communities.

2. **Accessibility -** As mentioned above, the rural nature of Oklahoma creates barriers to access. The telehealth services allow individuals who live in rural areas to access psychiatrists and other specialists who would otherwise be inaccessible without traveling long distances.

3. **Acceptability -** Not applicable.

Sustainability/ Expansion

Originally, a Transformation grant provided the seed money to install the systems. Now the State is working with Tanburg Grants Management in order to identify additional grant money in order to install the system in more counties. A maintenance contract purchased by the original grant keeps the technology maintained. State funding covers the FTE of the State coordinator, who promotes and installs the systems. The system is sustainable because it saves money. The State has estimated $190,000 per month savings within Oklahoma using this system due to decreased travel time for providers and increased productivity. The State is projected to save $3.5 million over the next 3 years using this system. Additionally, Medicaid reimburses providers at a higher rate for telehealth. Some stimulus funds are also going to the State for telehealth development. Finally, telehealth services are now a line item in the State budget. The administrator of the Telehealth Network in Oklahoma believes that with an appropriate amount of State-level buy-in, this system could be replicated in any State. He is currently consulting with five other states to help them set up a similar system.

Population Targeted Training

The Oklahoma Department of Mental Health and Substance Abuse Services provides education for both providers and consumers regarding the use of the Telehealth Network. A handout is available for consumers that outlines the process of using the system and describes the equipment involved. For providers, the State often helps the agencies implement the system first for the purpose of meetings and other administrative uses prior to using it for service delivery. This essentially serves as hands-on training, as the providers get used to using the equipment and interacting via video prior to using the system with patients/clients. Each facility is provided an administrator's guide on the equipment. IT managers as each facility are also provided with hands-on training in the operation of the equipment at the time of deployment.

Program Documentation

Telehealth policies and procedures are in draft format and are being reviewed and finalized by agency leadership. However, organizations are provided an electronic detailed map of Oklahoma's TeleHealth Network which lists all current telehealth locations throughout the State (physical address, IP address, contact person). The State also provides a user's guide for the telehealth equipment.

Collection and Use Of Data (Effectiveness)

Data collected by the system includes demographic, network usage, types of services being delivered, and outcome data (e.g. access to services, travel time for providers, quality of service, client satisfaction, number of clients served, operating efficiency, staff productivity, and accessibility to experts). These data can be collected online via the Telehealth Network system. An evaluation plan is currently being developed by the data services division of the State.

Regional Reach and Span

At the time of this interview, the Telehealth Network was set up and functional in 81 sites throughout Oklahoma, and was planned to be implemented in 24 additional sites by the end of the month. Anticipated expansion includes 126 sites in the next 18 months, which will include every county in Oklahoma.

Community Engagement

Because this system is implemented in CMHCs, community engagement is inherent to the Network. CMHC's across the State of Oklahoma have accepted and implemented the system and, as a result, have increased behavioral health services in their communities.

Strengths

This statewide system is the first of its kind in the United States. The most important strength of the Telehealth Network is that it greatly increases access to services in the State of Oklahoma. In a behavioral health crisis, the provider can be available to the patient immediately and can have access to their electronic medical records immediately without having to contact other providers. The State recognizes that the Telehealth Network does not have to be an "all or nothing" service, as some people are more comfortable receiving or providing care in person. Thus far, only one consumer has declined services via telehealth. Some providers have opted to travel into the patients' communities at some point during their telehealth service provision in order to meet their patients face-to-face. Another important strength of the system is that it is also used for State trainings and meetings, which cuts down State costs associated with travel.

Areas for Growth

One area of difficulty for the system has been that broadband internet connections are not available in some rural communities. Many communities are improving their internet capabilities in order to offer telehealth services.

Mid-Shore Mental Health Systems (Easton, MD)

The Maryland Mental Hygiene Administration, the University of Maryland, and three local mental health authorities (Mid-Shore Mental Health Systems, Garrett County Core Service Agency, and St. Mary's Department of Human Services) have partnered to bring telemental health services to rural Maryland. The Telepsychiatry Network utilizes four psychiatrists based at the University of Maryland to provide services to seven rural counties through the Community Mental Health Center partners, and the University of Maryland has contracted with other specialists to make available specialists in co-occurring disorders, child and adolescent psychiatry, and a Spanish-speaking provider. Based on its relationship with the University of Maryland, a researcher at the university developed a feedback questionnaire for the program to use to evaluate its effectiveness. A particular strength of the program is its reliance on a wealth of data, from clients as well as providers, to measure the program's effectiveness and ensure its future success (e.g., cost savings data) .

San Juan County Telepsychiatry Project (Friday Harbor, WA)

The San Juan County Telepsychiatry Project provides psychiatric evaluation and medication management to residents of San Juan County using Telepresence Tech equipment. The psychiatrist and patient see each other on video screens, and the visit is done in real time. The equipment is also used for continuing education for behavioral health providers. The Project provides both child and adult psychiatry services via telepsychiatry. The Telepsychiatry Project is run by the Inter-Island Medical Center, which applied for and received a grant from the Health Resources and Services Administration (HRSA) to increase access to and use of psychiatric services in the San Juan Islands. Through this grant, the Telepsychiatry Project was given access to an evaluator, and they have been collecting basic data including satisfaction surveys, the number of primary care visits before and after telepsychiatry, and medication use.

Seattle Children's Hospital Child Psychiatric Consultation (Seattle, WA)

The psychiatric consultation hotline through Seattle Children's Hospital provides consultations on child psychiatric issues to rural primary care providers. Providers call a hotline, and reach an administrative assistant who collects data on the child (demographics, medical history, etc.). The administrative assistant pages the consultant, who is often available to speak to the primary care provider immediately. The psychiatrist provides a consultation for the rural doctor, and, if therapy is recommended, contacts a social worker to identify a therapist in the area who could provide treatment for the child. There is no billing for the psychiatrist's time, due to a contract with Medicaid that underwrites the psychiatrist's time to ensure rapid availability to rural primary care providers. This flexibility allows psychiatrists to conduct telepsychiatry evaluations within a day or two with rural patients. The program connects with rural primary care providers by offering continuing medical education credits on a range of behavioral health topics to rural providers. The program collects a range of data as to its effectiveness, and has recommended reducing or stopping psychotropic medications in over 50 percent of consultations. Through the consultation program and the relationships Seattle Children's Hospital has developed with rural primary care doctors, children in rural Washington are receiving more appropriate care for their behavioral health issues, and are able to manage their behavioral health problems locally through provider education by psychiatrists.

University of Minnesota – Duluth (Duluth, MN)

The Center for Rural Mental Health Studies within the Department of Behavioral Sciences at the University of Minnesota Medical School runs a telemental health consultation service for rural primary care doctors. The consultation service provides telemental health consultation to primary care providers in six communities with no behavioral health professionals. Primary care providers schedule their patient to be seen by a psychologist or psychiatrist via a Polycom system. The psychologist or psychiatrist then gives the primary care provider information his or her consultation information within 48 hours of the video meeting. The program is funded through a variety of mechanisms: equipment for the program is funded by billing insurance for the telemental health meeting, psychiatrists are funded via a State contract, and psychologists work on a volunteer basis. The program is based on a strong relationship between the primary care providers and staff at the university. University staff travels to the primary care clinics to engage them and develop personal relationships with the primary care providers. In this way, the program is able to get to know the needs of the communities they serve and troubleshoot problems that prevent the program from working well.

Zia Behavioral Health (Santa Fe, NM)

Zia Behavioral Health is a large network of child psychiatrists that provides in-person therapy services and services via videoconferencing to rural New Mexico. The psychiatrists serve approximately 50 percent of the State and are aligned with local agencies, community mental health centers, and insurance companies. In addition to the psychiatrists, the program provides local support teams consisting of a case manager in serious cases, a paraprofessional, and a physician's assistant. The group provides case-specific training to these local teams by identifying training needs for the team and working with the team to develop a crisis plan. Zia Behavioral Health also trains communities in specific topics of interest to the communities (e.g., gay, lesbian, bisexual issues; psychotropic medications; bipolar disorder; traumatic brain injury). The program has recently begun working with an evaluator at one of the sites to determine its effectiveness.

Training

Eastern Tennessee State University (Clinical PhD Program in Psychology)

Summary of Practice

The clinical PhD program in Psychology at Eastern Tennessee State University (ETSU) has an emphasis on training students to practice in rural primary care settings. The program was developed six to seven years ago due to the rural focus of the ETSU health professional programs. ETSU received a grant from the Health Resources and Services Administration (HRSA) to begin developing the program, which enabled ETSU to bring in experts on integrated and rural care prior to starting the clinical PhD training program in Psychology.

 The program has 18 students, with additional students from a third class beginning this fall. There are nine clinical training faculty in the program, as well as nine experimental training faculty, and the program is in the process of receiving accreditation through the American Psychological Association. The training clinic includes a telehealth training program, which trains students to provide telemental health services for rural K-12 schools in North Carolina, as well as at rural hospitals. The students' clinic work also includes providing services in a rural primary care clinic, and they develop collaborations with other rural professionals in training (e.g., rural-track medical students) through group research projects.

The course work for the program offers a breadth of training in basic PhD-level courses, as well as courses specific to providing treatment in primary care settings (e.g., administrative and ethical issues that arise, what treatments work in primary care, and how treatments can be adapted to primary care). The students have a scaffold model of training, in which they first practice providing primary care behavioral health services to actors, then see patients in supervised primary care or telehealth clinic settings through externships at nearby integrated care practices, such as Cherokee Health (see above entry for Cherokee Health Systems)]. All students in the training program receive a minimum of approximately 1000 hours of experience providing behavioral health services in a primary care setting.

Criteria

Rural Specificity (Relevance)

The ETSU clinical PhD program in Psychology trains psychologists to practice in rural, integrated care settings. The program's location in and connections to rural primary care settings ensures high-quality training for students, who are expected to go on to practice in rural areas. Every aspect of the training program targets students for entering the rural workforce, including the research course and related projects, which are conducted in rural

communities with a team of other health professional rural-track students (e.g., medical students, public health students, and nursing students).

Impact

1. **Availability -** The ETSU training program is working to increase availability by increasing the number of rural-trained psychologists.

2. **Accessibility -** The training program focuses on preparing psychologists to work in settings that enhance the accessibility of behavioral health services for rural areas, such as in primary care settings and via telemental health services. In the process of adequately training students for enhancing the accessibility of rural behavioral health services, students are increasing the accessibility of services through their externships and clinic work.

3. **Acceptability -** For the research projects, students are assigned to a partner community, where they meet with community leaders, conduct an assessment, and intervention (such as a public health fair). These research projects enhance community members' knowledge about behavioral health, a lack of which is one of the biggest barriers to help-seeking in rural areas.

Sustainability/Expansion

The training program has relied on grants and external support to get started, but aside from these startup costs the program is able to be somewhat self-sufficient. Initial grants were needed to develop the training program, as well as to purchase 2-way videoconferencing equipment for rural training sites. The sites where students do their clinical externships pay for the students' services.

Program Documentation

The Clinical PhD Program in Psychology has its own website, which describes the program in detail. Students are recruited via advertisements, faculty travel within the region, and relationships with area universities. This past year, the program had 50 applications, with about half of the applicants from local areas.

The Clinical PhD Program in Psychology relies heavily on a standardized training program for all students, which is accompanied by a list of competencies (see the program website: http://www.etsu.edu/cas/psychology/graduate/programs/clinicalphd/mission.aspx). Their seeking of American Psychological Association accreditation ensures all students who complete the program have the same degree of training and preparation for clinical work in Psychology.

Collection and Use Of Data (Effectiveness)

The primary measure of the program's success is following students to see where they are employed after graduation. The program is still in its infancy, and only one student has moved on to a post-doctoral position. That student is currently at Cherokee Health (see above entry for Cherokee Health Systems, a rural, integrated care practice.

Community Engagement

The Clinical PhD Program in Psychology has been successful due to its high degree of engagement with the ETSU campus, as well as nearby communities. The program's relationship with other rural health professional training programs at ETSU is valuable not only for the training these collaborations provide to the psychology students, but also for the experience the medical, nursing, and pharmacy students receive in working with psychology students. In rural communities experience with these sorts of collaborations are extremely valuable for all health professionals.

The program's relationship and partnership with area integrated care sites provides an additional way to engage rural communities. These partnerships not only provide students with rural-focused training in providing behavioral health services, but they also enhance services to rural residents by providing additional staff to the communities participating in the training program. The research projects enable students in the program to additionally engage rural communities, and gain valuable experience working with community leaders to address health issues relevant to individual rural communities.

Strengths

The particular strength of the ETSU Clinical PhD program in Psychology is its provision of detailed, focused training in providing psychological treatment in a rural integrated care setting. The students not only learn about issues in providing behavioral health services in rural areas, but gain hands-on experience working in rural settings with primary care doctors, nurses, social workers, and other health professionals.

Weaknesses

As this program is still relatively new, its success in drawing more PhD-level psychologists to rural areas is not yet able to be addressed. However, the high number of applications to the program, and the rigor with which it has been developed, suggest the program will be highly successful in the coming years.

Overall Comments/Additional Observations

This program provides a unique and comprehensive training opportunity for future psychologists interested in working in rural settings. By providing rural-specific training, and introducing and familiarizing students with rural care settings during their graduate program, the ETSU Clinical PhD Program in Psychology enhances the likelihood of students working in rural areas after their degrees are completed.

Rural Human Services Program (Fairbanks, AK)

The Rural Human Services Program at the University of Alaska, Fairbanks, is a 32-credit, "grow your own" training program designed to train resident Behavioral Health Specialists in rural Alaska Native villages. The program teaches natural helpers in villages to provide basic, culturally-competent behavioral health services to community members in areas that would not otherwise have a behavioral health provider, and articulates toward an Associate and Bachelor of Arts degree. One of the main strengths of the program is the degree of collaboration between the University, State, and rural communities. In addition, the program is highly adapted to rural Alaskan communities, integrating Alaska Native culture and awareness into the training, as well as offering distance education and basing the course schedules around Alaska Native seasons and lifestyles. The program is collecting outcomes data, and has a mean 5.5 years on the job for individuals trained as Behavioral Health Specialists.

Fredericksburg Counseling Services, Inc. (Fredericksburg, VA)

Fredericksburg Counseling Services works with individuals who have no insurance, and fall within 200 percent of the Federal poverty guidelines. The agency provides services at no charge to individuals who do not have serious, major behavioral health issues and ongoing needs for medications, physicians, and strong continuity of care. In this way, Fredericksburg Counseling Services is able to treat clients who would otherwise be on waiting lists for months. The services at Fredericksburg are all provided by students and license-track counselors, rather than by licensed professionals. The students and counselors come from a dozen different local universities that offer practicums, and are supervised by local professionals who provide their supervision services free of charge. The students gain valuable experience providing behavioral health services in underserved, rural communities, and the communities benefit by gaining access to behavioral health services for individuals with lower level behavioral health needs. Through the development and maintenance of partnerships with professionals in the community, and with local university training programs, Fredericksburg is able to provide its community members with services that would otherwise be unavailable.

Appendix D: Web site Links

Administration for Children & Families, Office of Planning, Research, and Evaluation: The Program Manager's Guide to Program Evaluation

http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/index.html

CDC Evaluation Working Group

http://www.cdc.gov/eval/index.htm

Drug Abuse Treatment Cost Analysis Program

http://datcap.com/

Eastern Tennessee State University Department of Psychology

http://www.etsu.edu/cas/psychology/graduate/programs/clinicalphd/mission.aspx

Grants.gov

http://www.grants.gov/

Institute of Behavioral Research - Community Treatment Forms

http://www.ibr.tcu.edu/pubs/datacoll/commtrt.html - ComTreatmentCosts

National Organization of State Offices of Rural Health

http://www.nosorh.org/

Office of Rural Health Policy

http://www.hrsa.gov/ruralhealth/

Rural Assistance Center – rural health and rural human services information

Home page	http://www.raconline.org/
What is Rural?	http://www.raconline.org/info_guides/ruraldef/
Rural Funding Opportunities	http://www.raconline.org/funding/

SAMHSA's National Registry of Evidence-based Programs and Practices

http://www.nrepp.samhsa.gov/ViewAll.aspx

Substance Abuse Economics – RTI International

http://www.rti.org/page.cfm?nav=722

W. K. Kellogg Foundation Evaluation Handbook

http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx