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- November 15th for the Winter Issue.
- February 15th for the Spring Issue.
- May 15th for the Summer Issue.
- August 15th for the Fall Issue.

Inquiries about membership in NARMH may be sent to the above address or you may call (320) 202-1820 or (800) 809-5879. You can also access membership and other information from the NARMH web site (www.narmh.org).

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A Message from the President

by
Donald Sawyer



As the winter winds along, I find myself longing for the 2003 NARMH Conference in Orlando, Florida, July 17th through the 20th. Conference Chair Mary Van Hook and her Committee are doing wonderful work building an excellent agenda including three preconference workshops and over 45 breakout sessions. There is additional information about the 2003 Conference elsewhere in this issue of Rural Mental Health. Please become familiar with the conference agenda and by all means, consider attending the 2003 NARMH Conference. The conference brochure will be mailed in April.

NOTE! I am very pleased to report to the Membership, that NARMH was recently awarded a grant from the Alaskan Land Trust, to bring the Annual Conference to Anchorage, May 10th through 14th, 2004. This

means we have temporarily suspended work on our anticipated Colorado Conference. The Alaskan frontier is a fascinating environment in which to provide behavioral health care services and we are looking forward to superb presentations on treatment interventions and model programs not only from Alaskans, but also from other NARMH members around the country. Anchorage is very pleasant during May with an average daytime temperature of 55 degrees, wild flowers in bloom and wildlife on the move!

To give you a flavor of the Alaskan behavioral health care experience, we are reprinting an article from NARMH's Winter 2000, Partyline Magazine. Please consider attending both Orlando in 2003 and Alaska in 2004!

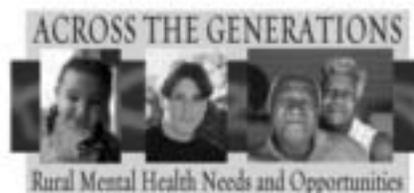
Exciting Agenda for NARMH's Annual Conference in Orlando!

NARMH's 2003 Annual Conference, "Across the Generations: Rural Mental Health Needs and Opportunities" will be held at the Grosvenor Resort on July 17-20, 2003 in Orlando, Florida. The Conference will address four critical themes in behavioral health care service provision and prevention:

- 1) Behavioral health concerns across the life cycle;
- 2) Effective partnerships to address mental issues across the life span;
- 3) Biological treatment in rural and frontier areas, and

- 4) Responding to diversity in rural communities and providing access to care for underserved groups.

There will be over 45 presentations on research and intervention models in rural behavioral healthcare in areas including substance abuse and co-occurring disorders, children's mental health, family services, partnerships with primary care, gay and lesbian issues, biological treatment, interventions for older adults, school based issues, and community develop-



ment.

In addition, this year's Conference will feature a presentation by Dr. Nancy Speck, NARMH member and a member of the President's Commission on Mental Health. Furthermore, there will be three pre-conference institutes to choose from. The first, presented by Garret Evans and his staff, will focus on a very timely topic: "Rural Community Mental Health Responses to Disaster, Trauma, and Terrorism." Topics to be covered include preparing and coordinating community responses to disaster events; controlling psychological contagion and panic; effective use of media and public service announcements; preparing and responding to the threat of terrorism and bioterrorism; and special considerations for responding to disasters in rural areas. The second institute, presented by staff of the Center for Mental Health Services (CMHS), will focus on rural and frontier agency and provider response to the challenge presented by the HIPAA Legislation. CMHS staff will be discussing and demonstrating several web-based tools, which can insure agency and individual providers comply with new HIPAA regulations. Russ Hunt, RN, will present the third preconference institute. Russ is a NARMH member and practicing Nurse Practitioner in Oregon. He will be discussing the "Art of Providing Effective, Affordable Biopsychosocial Mental Health Care" in rural and frontier America.

The 2003 NARMH conference brochure will be mailed in April.



Photos from Cumberland Mountain Community Services

Developing Mental Health Services for Deaf Persons in Rural Areas

by Michael Bush, LPC; Jana Dreyzehner, MD; Henry Smith, LCSW; Lorrie Taylor, BSW

When deaf persons seek mental health services, they are often confronted by a system that is completely inaccessible. Language and communication barriers, as well as cultural issues, often prevent the provision of even the most basic services. In some highly populated urban areas such as Washington D.C. there are specialized organizations that address the mental health needs of the deaf. In rural areas, however, services for this population are largely non-existent. Based on the experiences of a mental health program for the deaf in the Appalachian region of Southwest Virginia, this article proposes five recommendations for developing specialized services for the deaf in rural areas.

With the national prevalence of hearing loss at 8.6% (NCHS, 1994), there is no mental health system, rural or

urban, that is immune from serving the deaf and hard of hearing population. The low numbers of deaf clients actually seeking services, however, may lead administrators to believe that the needs of this population are being met, or that there is no major problem to address. Although the mental health needs of deaf persons are similar to the general population (Gore & Critchfield, 1992), it is estimated that only between two (Vernon, 1983) and ten percent (Steinberg, 1991) of deaf persons with mental health needs actually receive services. When Steinberg, Sullivan, and Loew (1998) investigated the knowledge, attitudes, and beliefs of deaf adults towards the mental health system they found a, "mistrust of providers," "profound concerns with communication issues in therapy," and a, "widespread ignorance about how to obtain services." With deaf persons often reporting that the mental health system is inaccessible to them (Pollard, 1994), the normal

meeting ground for this population and the mental health system seems to be situations of crisis.

Many excellent mental health programs for the deaf have grown out of litigation as the result of inadequate services rendered in crisis situations or the following care received in an inpatient setting. A consumer complaint assisted in establishing the Regional Deaf Services Program (RDSP) in Southwest, Virginia. A deaf man who was fluent in sign language was screened for psychiatric hospitalization by a community mental health agency who used the consumer's mother as an interpreter. The information that was obtained from the client was therefore filtered through an individual who had personal involvement in the situation, questionable sign language skills, and the belief that the client needed hospitalization. As a result of the crisis service, the consumer was hospitalized against his will. A complaint was filed and the issue gained recognition at the state level.

The State of Virginia, who already funded four regionally based mental health professionals for the deaf and hard of hearing, provided additional

funding for a position in Southwest Virginia. This region takes approximately 4 hours to drive from east to west and is comprised of 12 counties with a total estimated population of 381,109 people (Census Bureau, 2000). When Cumberland Mountain Community Services (CMCS) established the Regional Deaf Services Program in the Fall of 1999 there were six deaf clients being served by the five community mental health agencies who cover the region. RDSP has provided mental health services to over 60 persons since program inception, currently maintains an active case-load of more than 35 persons, and averages one new referral per month. It is now estimated that 30% of deaf persons who have mental health concerns in this region are receiving services. Although the professional literature reflects the growing interest in developing specialized and culturally sensitive mental health services for the deaf, there is little information specific to developing programs in rural areas. This article provides five recommendations for agencies in rural areas who wish to reach out to this vastly underserved population.

1) Focus on Providing Services in Sign Language

With the low number of deaf persons seeking services, it may be tempting for a rural mental health agency to address this population by simply getting a list of sign language interpreters in the area who can assist already existing clinicians in providing services. Although this is a necessary step in the right direction, especially with the provision of crisis services in mind, the use of interpreters as an end-solution brings several problems. The first is the fact that deaf persons will not walk in the door because a list of interpreters is in place. Second, there is an extreme shortage of qualified sign language interpreters in most rural areas. Third, there are many complicating factors and complex dynamics which accompany bringing a third party into therapy as the median between two persons who have a different language and a different culture. The alternative to using interpreters is to provide services to deaf consumers directly in their preferred communication mode, which is often sign language. RDSP hired a sign language fluent clinician, called the Regional Coordinator, who was trained and experienced in working with deaf and hard of hearing persons. As a long term approach, the benefits of providing mental health services in sign language can not be overemphasized. In light of the fact that deaf consumers view communication issues as a major contributor to their mental health concerns, it is not surprising that they also view sign language fluency as an essential quality of mental health professionals (Steinberg et. al., 1998). At the time of program inception, CMCS was fortunate to already employ a psychiatrist on a contractual basis who was fluent in sign language. With a team of specialized "direct service" professionals in place, the newly formed RDSP provided outreach to the deaf community.



2) Establish an Aggressive Outreach Program

In addition to providing mental health services in sign language, it is also possible for a sign fluent professional to build relationships with the leaders of the local deaf communities. With the assistance of deaf leaders, RDSP hosted “community dinners” around the region where the Regional Coordinator and the psychiatrist introduced themselves and discussed the mental health services now available in sign language. Community members performed skits to provide education on situations where a person might benefit from mental health services. This outreach went a long way to de-stigmatize mental health services and to reduce the widely held belief that seeking help inevitably leads to an involuntary hospitalization. Many deaf persons sought out services after attending an outreach activity. Referrals also came from other state and community agencies that serve the deaf community. Most notably, the Virginia Department of Rehabilitative Services and the local Centers for Independent Living employed deaf professionals who knew of individuals in need of services. By establishing and maintaining an aggressive outreach program, RDSP has also located many deaf and hard of hearing persons with mental health concerns who are not connected with the deaf community. Unlike many urban areas with vibrant and self-supporting deaf networks, many persons who are deaf in rural areas are largely isolated from other people who use sign language. In many current cases, the signing mental health provider is the only sign fluent individual in the consumer’s life. Expanding a person’s social network is a common treatment goal.



3) Begin with Community Based Services and Centralized Psychiatric Services

RDSP initiated services with a focus on providing clinic based psychotherapy services at different locations throughout the region. This model was selected based on the successful experiences of the other regional programs in the State of Virginia that are located in more populated areas. As program referrals increased, however, it became apparent that a community-based model of case management services was better suited to actual consumer needs. The Regional Coordinator now spends a majority of his time in the community engaged in case management activities such as monitoring mental health symptoms, coordinating medical care, linking consumers to assistive technology equipment, advocating to make other community services accessible, providing supportive counseling, and monitoring medications. What has been successful through the program’s history is the centralized provision of psychiatric services. The sign language fluent psychiatrist conducts psychiatric evaluations and medication clinic two days a week in an office which is central to the region and shared by other RDSP staff. RDSP has reduced the impact of staff

travel time by piggybacking on the region’s already established teleconferencing network. The Appal-Link Network of Virginia provides 10 sites within the region that are equipped with state of the art teleconferencing equipment. Deaf consumers typically see the psychiatrist in person for their initial psychiatric evaluation and then attend follow-up medication clinics through their local Appal-Link site. Three years of experience has shown teleconferencing to be an effective and promising tool in providing mental health services to persons who use sign language. If a signing psychiatrist was not available, RDSP would still desire to centralize psychiatric services by pairing a nationally certified interpreter with one psychiatrist who is interested in learning about deaf culture and the unique diagnostic and communication issues related to this population.

4) Establish a Unique Deaf Services Program Identity

In fiscally austere times, a rural mental health agency may not have the financial resources or the necessary number of existing deaf clients to stand-up a specialized program on their own. CMCS partnered with four other community mental health agencies to establish RDSP. In this



sense, RDSP is similar to other initiatives within the Appalachian region to build agency coalitions in order to provide a specialized health service. Although administered by CMCS and supported by partner mental health agencies, RDSP has established a unique deaf services program identity. This identity has been reinforced by the centralized psychiatric services as well as the fact that RDSP “owns the cases” of the consumers being served. RDSP maintains consumer charts in accordance with the policies of its parent agency and bills third party payers for the services it provides to deaf consumers across the region. The revenue generated by RDSP from billing for services has further enabled the program to hire a full time Case Manager for the Deaf. Establishing a unique program identity has proven beneficial in two key ways. First, the deaf community has the opportunity to see RDSP as a new entity which assists in breaking the old stereotypes and myths that are associated with the various mental health agencies in region. Second, a unique program identity has assisted in attracting a team of specialized mental health providers. The Regional Coordinator was attracted to this position largely for the opportuni-

ty to coordinate a “program” and also to work with a sign language fluent psychiatrist. The Case Manager for the Deaf, who is hard of hearing herself, was attracted by the opportunity to work with deaf and hard of hearing clients, as well as the opportunity to work with a team of sign language fluent professionals.

5) Coordinate Accessibility Across the Continuum of Care

Providing direct services in sign language across the entire continuum of care may never be possible in a rural area. Having a signing provider in one key area, however, such as case management, greatly assists deaf consumers in maintaining a connection with the mental health system. In areas in which RDSP does not yet provide direct services, such as intensive mental health supports and residential services, the Regional Coordinator works closely with partner mental health agencies to coordinate accessibility with existing services. This is accomplished by providing education on the Americans with

Disabilities Act, consulting on the use of technology to provide communication access, providing training on deaf cultural issues, and assisting in locating and working with qualified sign language interpreters. In the important area of inpatient treatment, RDSP benefits from a close relationship with the Mental Health Center for the Deaf, a culturally sensitive inpatient facility at Western State Hospital in Staunton, Virginia. The Mental Health Center for the Deaf employs a sign language fluent psychiatrist, psychologist, counselor, and social worker and provides patients the incredible benefit of receiving treatment with deaf and hard of hearing peers. The use of teleconferencing equipment to connect patients at the hospital with family members and treatment staff in the community lessens the impact of the 250 mile distance between this facility and Southwest, Virginia. Although making a local inpatient facility communication accessible is always a placement consideration, most deaf persons prefer to travel to a facility that provides communication freedom and a treatment environment where deaf culture is understood.



Summary

Establishing a specialized mental health program for the deaf in a rural area has been a successful and rewarding venture for both consumers and professionals. Every rural region will have unique challenges and unique assets in their ability to make the entire continuum of care accessible to this population. The first step is gaining an awareness of the large unmet mental health needs of deaf and hard of hearing persons that exist in almost every community. The next step is making a commitment to serve this population without waiting for a crisis experience to force the issue. Our experience in Southwest, Virginia has shown that signing professionals who are sensitive to deaf culture can bridge the gap between the hearing world and the deaf world and effectively locate and serve 'hidden' consumers before they show up in crisis situations. Future projects for RDSP include establishing residential services for the deaf, providing intensive mental health support services in sign language, and making psychiatric day

programs more accessible by hiring sign fluent staff or training current employees. Rural agencies who are interested in establishing specialized services for this population are welcome to contact RDSP for feedback, ideas, or assistance. Please contact Michael Bush by email at: mbush@cmcsb.com, by telephone at (276) 889-3785, or by TDD/TTY at (800) 347-4939.

Authors: Michael Bush, LPC; Jana Dreyzehner, MD; Henry Smith, LCSW; Lorrie Taylor, BSW

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Photo by Lynda Farrell, Crossroads Services, Farmville, VA

Challenges and Insights in the Development of a Complementary Therapies Program in a Community Mental Health Center

by William Collinge, Ph.D., Roberta Wentworth, L.C.S.W., L.M.T. and Sherry Sabo, Ph.D. Counseling Services, Inc.

ABSTRACT

Complementary therapies are experiencing dramatic increases in utilization, and a surprising amount of this utilization is by people seeking help for concerns related to their mental health. There is evidence that complementary therapies can have effects that are beneficial to mental and emotional well-being, and there is interest by clients of mental health centers in exploring such therapies. This paper discusses the experience of one mental health center with three satellite offices in the development and imple-

mentation of a complementary therapies program for long-term clients with trauma. It describes experiences pertaining to the management, staffing and fund raising to support the program, and offers insights that other centers may wish to consider as they explore the possible integration of complementary therapies with traditional mental health services.

BACKGROUND

Utilization of complementary and alternative medicine has grown rapidly in recent years. A recent survey found that such therapies had been tried by two-thirds of Americans -- including three of ten pre-baby boomers, five of ten baby-boomers,

and seven of ten post-baby boomers -- and that such utilization crossed all socioeconomic groups (Kessler et al., 2001). Of particular interest to mental health agencies are findings that mental health problems are among the most common reasons people seek complementary therapies. These reasons include anxiety, affective disorders, substance abuse, fatigue, insomnia, chronic pain, depression and stress-related problems (Eisenberg et al., 1998; Bausell et al., 2001; Yager, Siegfried, DiMatteo, 1999).

In a national survey of over 9,000 respondents, Unutzer et al. (2000) found that 21% of individuals using complementary therapies in the past

year met the diagnostic criteria for a mental disorder, and that people with panic disorder and major depression were significantly more likely to use complementary therapies than people without those disorders.

It is clear that complementary therapies enjoy wide interest, acceptance, and use across a wide spectrum of both physical and mental health problems. Evidence on the mental health benefits of various complementary therapies has been reviewed elsewhere (Peeke and Frishett, 2002; Ernst et al., 1998; Field, 1998; Winstead-Fry and Kijek, 1999). Taken as a whole the evidence indicates that some complementary therapies can contribute positively to mental health outcomes – particularly symptoms of anxiety and depression, which are, of course, endemic in the population of clients presenting to mental health centers for care.

ONE MENTAL HEALTH CENTER'S EXPERIENCE

Counseling Services, Inc., founded in 1971, is a comprehensive community mental health center serving the southernmost county in Maine (York County) with a population of 193,000. The service area covers 991 square miles and consists of small coastal communities, small inland towns, and large rural areas. The agency has a \$14 million budget and outpatient facilities in four communities. Clientele are mostly low income, with 80% of the budget coming from Medicaid, federal and state grants.

In the spring of 2000, as a result of several factors coming together, we decided to create a complementary therapies (CT) program on a pilot basis. One of the key factors influencing this decision was the observation that approximately 70% of clients being served by the agency were long-term sufferers from some form of trauma that was responding very slowly to conventional outpatient

treatment. In addition, several clients had begun exploring complementary therapies on their own initiative and had brought this up in their outpatient therapy sessions. Of particular interest to us were published research findings indicating that massage can be therapeutic in treatment of sexual trauma (Field, et al. 1997), which was present in a high proportion of these clients; and that energy-based touch therapies can reduce anxiety and depression (Winstead-Fry and Kijek, 1999).

Another factor was the experience of one of our senior clinical social workers (RW) who sought and received training in massage therapy and Healing Touch on her own, after serving on the adult services staff for seventeen years. In her part-time private practice with these modalities she began to notice important clinical benefits for clients suffering from anxiety, depression, dissociation, bodily shame and other trauma-related symptoms.

These observations led to discussions with the C.E.O. (SS) to explore various scenarios for offering complementary therapies to clients of the mental health center. A plan emerged for a service that would be truly integrative; i.e., complementary therapies would be integrated with conventional mental health services in the community.

In the model that was developed, clients are referred to the program by their primary care mental health practitioners within the agency. Referrals are based on the clinical judgment of the practitioner, the client's expression of interest in complementary therapies, and consultation with the program manager (RW).

Since the beginning of the program, approximately 55 clients have been referred and about 30 have completed two or more sessions, with an average of about five sessions per participant. A recent review of cases found the most prominent diagnosis to be

PTSD, followed in order by major depression, anxiety disorders, and dual diagnosis.

Because complementary therapies are not historically a part of the traditional community mental health service model, the planning and development of this program called for innovation in the areas of management, staffing, and fund raising. Our experience with each of these areas is discussed below.

Management

In terms of organizational structure, the CT program is one of several services administered by the Primary Care Support Program. Other support services include housing assistance, financial assistance, social clubs, a short-term crisis stabilization unit, and psychiatric nursing services, all of which are available to support clients who receive outpatient therapy in the Primary Care Program.

The biggest commitment the agency has had to make is to free up staff time for a coordinator of the CT program. Initially the coordinator's role required four to five hours per week, and the rest of her time was filled with other support activities.

However, it has since grown into a full time position. This has represented an important commitment on the part of the agency because neither the position nor the program itself is income-producing for the agency. The tasks of the coordinator include:

- Preparing program descriptions and publicity about the program
- Helping write grant requests
- Providing some CT direct services
- Developing policy, procedures and guidelines for the program
- Recruiting, credentialing, and negotiating contracts with CT providers
- Training CT providers in working with mental health issues
- Educating mental health staff about appropriate utilization of the CT program

- Coordinating all paperwork related to quality control and accountability
- Coordinating communication between mental health staff and CT staff
- Screening and approving all referrals from mental health staff to the program
- Assigning the client to a modality and a CT practitioner
- Approving CT providers' billing to the agency
- Overseeing data collection from clients for program evaluation purposes

In addition the coordinator meets with funding sources periodically to keep them informed of the progress and status of the program. While some of the above tasks were one-time start-up activities, several require the on-going attention of a full-time coordinator.

The coordinator also devotes significant time to making the clinical staff aware of the complementary services. We strive to enable all clinicians to experience the modalities we are using in the program at least once at no cost. We attempt to make such experiences available to support them at times of personal need, as well as to give them an experiential basis to call upon when making referrals.

Overhead.

While the coordinator time is the major cost to the agency, the program does have other costs. Each of the three outpatient service sites has one treatment room set aside for complementary therapy services (equipped with a massage table and massage chair), so there is some cost in terms of space rent and utilities. There is also the cost of the coordinator's office space and phone. Finally there are the costs of photocopying and clerical time for supporting the activities of the coordinator, although clerical support is provided within the context of the larger Community

Support Services program within which the CT program is housed.

Staffing

The modalities of greatest interest to mental health centers, by virtue of their non-invasiveness, apparent benefits for mental well-being, lack of risk or side effects, and the availability of practitioners, are massage and energy-based touch therapies (i.e., Therapeutic Touch, Healing Touch, and Reiki). From a staffing point of view, one of the interesting aspects of the field of complementary therapies is that massage and touch therapies are represented by wide availability of providers in many communities.

Most states have laws regulating the practice of massage therapy, and many communities—including rural communities—have individuals who are licensed or certified in massage therapy. Likewise there is wide availability of individuals trained in energy-based touch therapies such as Therapeutic Touch, Healing Touch, and Reiki. The nursing profession is a particularly good source of practitioners in energy-based touch therapies, as these have been widely used for many years for pain control and comfort care in hospitals. There are also growing numbers of lay practitioners of touch therapies.

Theoretically, to the extent that a particular form of complementary therapy can make a meaningful contribution in mental health care, a mental health center may be able to significantly increase its number of points of service in its own catchment area through collaborative relationships with CT practitioners. This requires, of course, that such practitioners have the maturity and a level of professionalism that enables them to work in a collegial relationship with a mental health practitioner.

In our case, we assembled a team of CT providers who function as inde-

pendent contractors with the agency. They consist of a Reiki practitioner, two Healing Touch practitioners, one of whom is also a licensed massage therapist; two other licensed massage therapists, and one licensed acupuncturist (non-physician). These practitioners were carefully screened and selected based on their experience, maturity, personal knowledge of their work by the program coordinator, and their willingness to work in a close collaborative relationship with the agency and mental health staff. There are many other practitioners available in our service area who are potential candidates for participation on the team should the program continue to grow.

We have found it is important to have a choice between hands-on techniques such as massage, and energy-based touch therapies, which can be done "off-body" – i.e., in the energy field surrounding the body with no actual physical contact. This allows clients who have been physically abused to be helped without direct contact, until they are ready to receive it.

CT practitioner role.

These practitioners perform four primary functions. First, receiving referrals from the mental health clinicians involves an initial collaborative visit with both the practitioner and the client, which may take place either at the mental health center or at the CT practitioner's office. Second, providing a series of sessions in the particular modality usually includes five to ten sessions. Third, maintaining an open channel of communication with the mental health practitioner requires giving and receiving feedback about the client's progress and his/her experience of the complementary therapy during the course of the sessions. Fourth, the completion of paperwork associated with the service includes progress notes and summaries, and ensuring that the client completes instruments being used for program evaluation purposes.

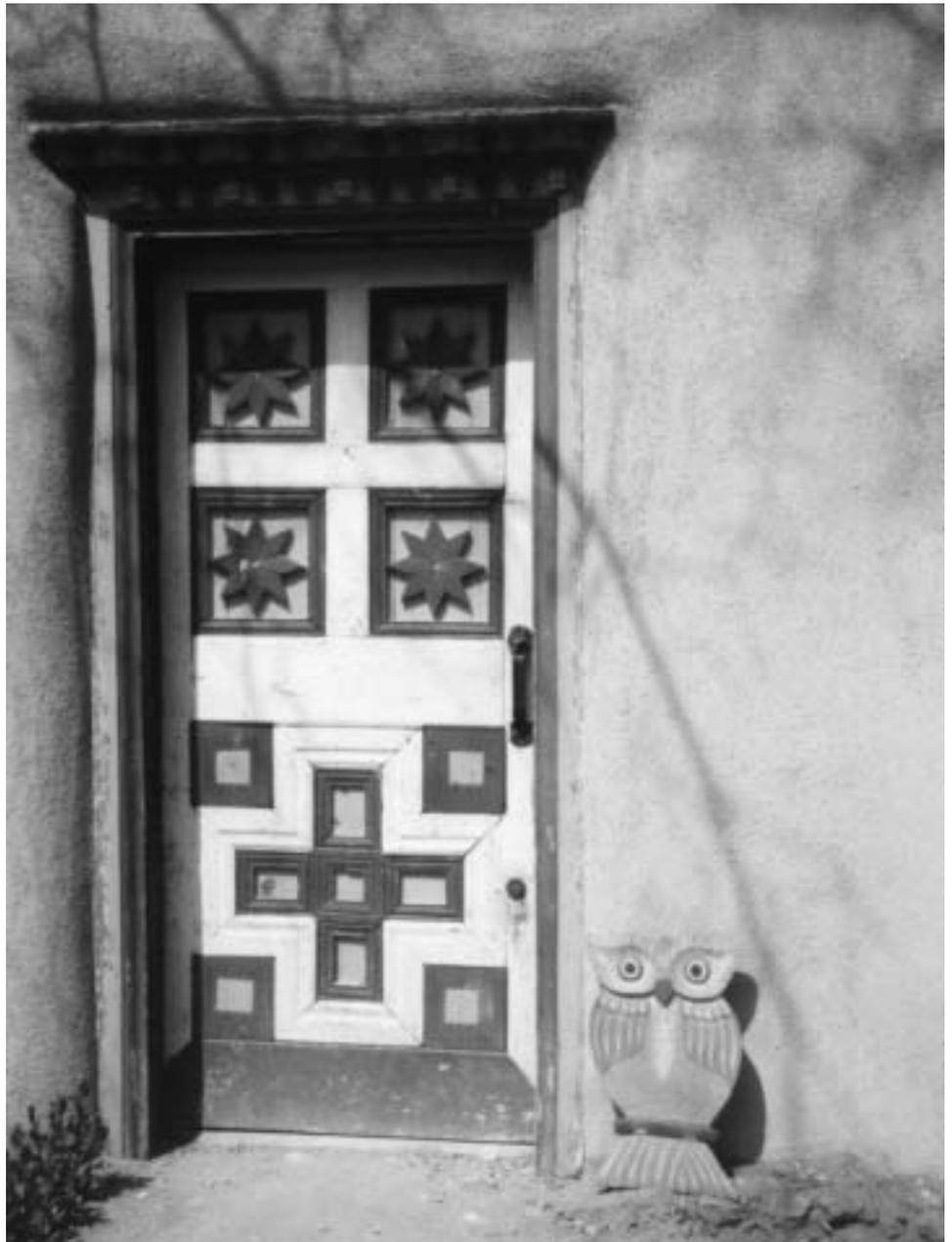
We have found that with the responsibilities described above, it is critical that the CT practitioner have a high level of commitment to the program and to the concept of collaboration with mental health center staff. To support the CT staff we periodically hold retreats in which both they and agency staff participate for purposes of team building and continuing education.

Payment of CT practitioners. Our experience has been that a highly professional and collaborative relationship with mental health staff is required of the CT providers. The importance of this cannot be overstated. Hence the appropriate payment of CT providers is essential. They are often required to give time to collaborative phone calls and paperwork outside the treatment session.

Coordination with psychotherapy services, reporting of clinical observations, and case discussion are critical to success and the viability of the service. We would thus discourage consideration of pro bono or reduced-fee arrangements with CT providers, even though they may at first express strong interest in an affiliation with a mental health center as a means of promoting their own practice in the community.

The CT providers bill the agency for their services. An important issue has been the handling of no-shows. The policy is to pay the CT provider full fee for no-shows. We absorb the risk of the no-show rather than asking the CT provider to, and this is based on our desire to retain CT providers and not have them leave the program for financial reasons.

This has made it necessary that we inform clients about a strict policy regarding no-shows. At this time the policy is that one no-show can be rescheduled, but two no-shows triggers expulsion from the program.



Colorful door of adobe casita in Northern NM. Photo by Chris Pederson

CT practitioners may use either their own private office or the facilities available at the agency to provide their service. We do not pay for mileage for those who use the agency facilities.

Fund Raising

Virtually all of the clients using the services are low-income, Medicaid clients, who would be unlikely to afford the services if we attempted to attach a fee. Hence we have never billed clients for the services and have chosen instead to base the services

entirely on funds specifically earmarked for this program.

Small donations. Through our fund raising efforts we have found that the program makes an attractive service for funding by small private donors and foundations. Donations of \$500 to \$1000 that were earmarked for complementary therapy services have made a big difference in the viability of the program, particularly in its early stages. We have found that many donors will consider making a small donation for one or two years.

United Way. We were successful in receiving a small grant from the United Way in the early development of the program based on their interest in supporting the concept of “wellness services” for underserved members of the community. Since a high percentage of clients in the program are long-term clients, we were able to convey the potential wellness-related benefits to this population in the grant application.

State funding.

Some of the most significant and symbolically important funding we have received has come from the state mental health system. This was a direct result of positive long-standing relationships between the agency and individuals in administrative positions with the state mental health program.

Because of close working relationships and positive rapport over many years, we were approached by the state at the end of one of its funding cycles with the information that there were funds still available from a special allocation earmarked for trauma services. Administrative staff from the state knew of the complementary therapies program which at that time we were funding entirely from private donations. They asked if we might have a use for these funds within the program.

Since a high percentage of clients in the complementary therapies program suffer from trauma, we were able to identify clients in this program as potential beneficiaries of the funds. We reached an agreement with the state that the funds would only be used for direct services. Thus, the funds were used to provide CT treatment for a fixed number of clients and sessions, with the agreement that evaluative feedback would be provided when the money was used up.

Obviously for the state to support an innovative and unproven program

such as this represented somewhat of a breakthrough. In retrospect, we believe this only happened because of the good will and positive reputation the center had developed over many years with the state agency. This is another example of the value of positive long-term relationships for fund raising.

Framing the concept of the program. We have found that emphasizing the concept of “wellness” has been useful in fund raising for this program. In describing the program, framing it as a wellness-related program seems to make it a more attractive target for funding than framing it as a program to treat mental illness or pathology of a certain kind. It has also been helpful to point out that we seek to serve a client population this is underserved or otherwise unlikely to enjoy the benefits of wellness-related programs because of economic disadvantages. These conceptual nuances have been helpful in enabling donors to feel a sense of pride that they are giving to an innovative program that is elevating the well-being of people in the community. Many large companies build funds into their budgets for supporting community well-being in a variety of ways.

Because indirect costs of the program are absorbed by the agency, we are able to offer potential funding sources clear vision of how much direct service their funds will purchase. For example, a \$6500 donation will enable ten individuals in need to have a complete series of ten massage therapy sessions to accompany their psychotherapy.

It has also been our experience that the concepts of “wellness” and “complementary therapies” are currently of great interest to the news media and lend themselves very well to human interest articles in local newspapers. This helps with publicity about the program and may help reach potential donors.

Evaluation of services.

Because this is an innovative and somewhat unorthodox approach to mental health services, we recognize that data collection to evaluate the outcomes will be critical to future fund raising efforts, especially if the program is to grow. We began collecting qualitative feedback from clients after they completed the services by use of a brief interview of satisfaction and their observations about their experience of the program. These interviews have brought consistently strong positive feedback and have included anecdotal reports of the program helping clients to accelerate their progress in psychotherapy. These observations have been confirmed by the clients’ therapists.

Recently we established a formal data collection regime using standardized instruments to evaluate clinical impact of the program. The instruments are assessing change in trauma-related symptoms, general psychiatric symptomatology, client health behavior and satisfaction with the program. We hope to build a base of evaluative data that will aid us in refining the program and expanding our fund raising efforts.

Discussion

Our experience is that a complementary therapies program within an established mental health center can be started with very small sums of money and can grow over time. The development of this program has required innovation in several areas. Individual agencies will of course have to find their own strategies for innovation, and there are obviously many different approaches to the integration of this type of service into an existing mental health center.

We have endeavored to frame the program conceptually in ways that respond to the expressed interests of funding sources. For example, by responding to the state’s interest in trauma services and the United Way’s

interest in wellness services, we have been successful in creatively bringing together sufficient funding to help the program get off the ground. It has been our observation that people working in administrative roles in state government and other potential funding agencies have a real need to feel they are supporting creative and innovative solutions.

The utilization of existing practitioners in the community who can provide complementary services has some interesting advantages in a rural context. It means that while a mental health center may have a small number of satellite offices covering a large geographic region, its reach is extended into other areas when CT practitioners are providing services in their own private offices. This may allow clients in remote areas to receive significantly more help than if they had to travel longer distances for outpatient therapy and were unable or unwilling to do so. In effect, the number of points of service of a mental health center can be increased by integrating services from a number of CT practitioners in a large rural catchment area. In our experience, CT practitioners have used their own private offices to serve our clients and this has not been problematic.

In summary, our experience has been that complementary therapies hold the potential of benefiting difficult-to-treat clients, and of attracting funding sources who value novel and innovative approaches to mental health care. We also see this service as a potentially cost-effective strategy by which rural mental health centers can extend their reach across wide geographic areas without having to add more satellite clinics. We look forward to sharing more systematic findings in the future, and to hearing of the experiences of other centers who are attempting innovation in this growing and promising area.

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The Effects of Family Resiliency Resources on Functioning Among Rural Families Experiencing Economic Hardship - A pilot study

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Introduction

Research on family resiliency focuses on identifying the resources that contribute to a family's ability to overcome normative and non-normative stressful conditions. The present study examines the relationships among economic hardship, family resiliency, and family functioning.

Twenty-three families who met or fell below the definition of poverty-level income and whose children attended preschool centers participated in this pilot study. Economic hardship was operationalized by the federal poverty level (Department of Health and Human Services, 1998). The

Resiliency Model of Family Stress Adjustment and Adaptation (McCubbin, Thompson & McCubbin, 1996) was used as an analytic framework. Resiliency was operationalized using the Family Hardiness Index (FHI) (McCubbin, Thompson, & McCubbin, 1996). The family's social support was measured using items that were developed for this study based on Barrera's (1981) conceptual framework. Overall family functioning was measured with the Family Assessment Device (FAD), version 3 (Epstein, Baldwin, & Bishop, 1981).

Data analysis used an incremental regression analysis to obtain regression coefficients and to assess the contribution of the various models in

explaining total family functioning. A moderate correlation ($r = -.60, p = .005$) was found between family hardiness and family functioning, and between social support and family functioning ($r = -.49, p = .02$). Income was not significantly correlated to family functioning ($r = -.37, p = .07$). Together, income and the resiliency resources (family hardiness and social support) explained 44% of the families' level of functioning. Income alone explained only 13.4% of the family's functioning. Realizing that a family's measure of resiliency can explain almost half of its functioning, these findings suggest that practitioners, as well as clients, should focus on the family's and community resources in order to overcome stresses in their lives.

Promoting family resiliency has implications for policy practice as well. By supporting programs that contribute to strengthening individuals and families, such as funding affordable community based educational, vocational, and family counseling services, social workers can contribute to family, individual, and community resiliency.

Literature Review

The Resiliency Model of Family Stress, Adjustment, and Adaptation (The double ABCX model) (McCubbin, Thompson, & McCubbin, 1996) states that each family strives to maintain a balance between ongoing challenges and demands. Successful achievement of a balance, especially in light of major demands (or crisis situations), is what makes a family resilient (Patterson, 1997). Previous research on family stress has focused on the effects of nonnormative, acute external events on the family, such as death, war, and natural or man-induced disasters. Social sciences have also inspected the effects of persistent, long-term stressors, such as chronic illness, unemployment, military service overseas, and separation due to war imprisonment (Lavee, McCubbin, & Olson, 1987). In addition researchers have attempted to learn the effects of pileup demands (stressful life events, normative transitions, and intrafamily strains) on family well being (Lavee, McCubbin, & Olson, 1987). In these studies, family financial condition served as a descriptive variable. Research focusing on long-term poverty, especially that of working poor families, and the importance that family resiliency resources have on these families' functioning, is non-existent.

The purpose of the present study is to examine the effects of family resiliency resources, family hardiness and social support, on families' ability to maintain healthy functioning in spite of experiencing economic hardship.

This study contributes to a clearer understanding of those protective factors available in the family and in the community that support healthy family functioning and that enhance resiliency in families who experience economic distress. Results will contribute to service planning and social work practice with those families who struggle and demonstrate resiliency in spite of continuous economic hardships.

Three major research questions guide this study. The first question is "is economic distress related to family functioning"? The next question is "is family resiliency, defined as family hardiness and social supportive relationships, positively related to family functioning"? and the last question is "Do family resiliency resources (hardiness, and social support) matter in a family's positive functioning"? While these questions are important for all families, this study targets rural families- an important group given the long term poverty present in many rural families.

Poverty and economic hardship
Increasing numbers of families with children in the United States are experiencing economic hardships. In 1997, the overall poverty rate was 13.3 percent, which represents a total of 35.6 million people. Of them, 11.6 percent were families and 21 percent (5 million) were children under six (U.S. Census Bureau, 1999). Poverty is not just a problem of joblessness, it is also a result of being part of a contingent workforce characterized by incomes that are either too low, unsteady employment, or unreliable wages because of a part-time job status. In 1996, 58 million families, or 7 percent of all families with at least one member in the labor force, were classified as working poor (Quan, 1997).

Poverty can be defined in terms of absolute deprivation, namely the

inability to afford minimal standards of food, clothing, shelter, and health care. In 1998 the federal poverty measure for a family of four (two adults and two children) is \$16,450 (Department of Health and Human Services, 1998). However, poverty can also be described in terms of the perception that the family has of their economic hardship. Economic hardship has been defined as the "aspects of economic life that are potential stressors for individuals and families" (Voydanoff, 1991, p. 432).

Previous research revealed that economic distress has negative effects on family functioning. It destabilizes marital relationships and can lead to family conflict, violence, and family dissolution (Conger, Ge, Elder, Lorenz, Conger, Simons, Whitbeck, Huck, & Melby, 1990; Voydanoff, 1991). The experience of economic hardship has also been shown to effect the psychological well being of the parents and as a result the employment of harsh disciplinary practices with their children (Conger, Elder, Lorenz, & Simons, 1994; Fisher, Fagot, & Baldwin, 1998).

Economic distress has further been associated with increased incidence of child neglect and abuse (Gaudin, Polansky, Kilpatrick, & Shiton, 1993).
Family Resiliency
Family resiliency has been defined as "the ability of the family to develop and/or maintain healthy family functioning and successfully adapt to life's challenges and risks" (Patterson, 1997, p. 8). Research studies on resiliency in families are limited, and have mostly been focusing on identifying the characteristics or special traits of resilient, well functioning families (McCubbin, Thompson, & McCubbin, 1996). Based on few yet large-scale studies of families who experienced acute stress family scientists concluded that the amount of stress a family encounters as well as family strengths, skills and competen-

cies vary across the stages of the family life cycle. Family strain is directly related to the family having children, and the children's ages, reaching the highest point when the children are adolescents and dropped when couples were older and their children left home (McCubbin & McCubbin, 1988). Stressors and strains included such variables as balancing work and family, financial strains, intrafamily strains, life cycle transitions (e.g., pregnancy, members moving in and out of the home) and illness, losses, and retirement. The resiliency attributes that facilitated adjustment and adaptability included family accord (low conflict), satisfying marital communication, good relationships with family and friends, agreement on finances, enjoyment of children, family and life satisfaction, enjoyable leisure, family time together, personality compatibility, and satisfying sexual relationship.

Family research further concluded that at each stage of the life cycle a family's ability to adapt to normative transitions and stressful life events appeared to be facilitated by four major factors. These include family members' personal resiliency resources such as high self esteem and self-reliance, the family's shared belief and meaning they makes of a challenge such as optimism, spirituality, and cultural heritage. These also include social support from family, friends and the larger community and the family coping strategies and the techniques they use to solve their problems and maintain family integrity (McCubbin & McCubbin, 1988). Family resiliency as conceptualized in this study

Family resiliency resources are the "family system qualities that make the family less vulnerable to stress and/or better able to withstand the impact of stressors and crises" (Lavee, McCubbin, & Olsen, 1987, p. 859). Two types of resiliency resources are

examined in this study: family hardiness, and social support. Family hardiness is defined as the "internal strengths and durability of the family unit" and is characterized by "a sense of control over the outcomes of life events and hardships" (McCubbin, Thompson, & McCubbin, 1996, p. 239). Family hardiness consists of three interrelated factors: commitment or a sense of meaningfulness about life, challenge or the belief that change is expected and presents an opportunity for growth, and internal/external control or the belief that one can influence the course of events. Social support is defined as "the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us" (Sarason, Levine, Basham, & Sarason, 1983, p.127). Social support can be organized into three broad categories: social embeddedness, perceived social support, and enacted support (Barrera, 1986). Social embeddedness refers to "the connections that individuals have to significant others in their social environment" (Barrera, 1986, p. 415). Perceived social support is the cognitive appraisal of availability and adequacy of supportive ties when needed. Enacted support refers to the "actions that others perform when they render assistance to a focal person" (Barrera, 1986, p. 417).

Research studies on social support and its effectiveness of helping people experiencing economic distress are scarce, and evidence of success of such effects is mixed. Some studies indicate that there is increased support and responsiveness to requests for assistance for the poor especially from family members, relatives and friends (Auslander & Litwin, 1988). Other studies cite a decrease in the size of and contact with nonfamily social networks when people became unemployed (Voydanoff, 1991). However, when support is available and used, it generally is associated

with increased psychological well being and quality of family life among families experiencing economic distress (Gladow & Ray, 1986). Social support is associated with positive parental functioning by Head-Start parents, especially for fathers (Roggman, Moe, & Hart, 1994) and with increased responsiveness in mother-infant interaction in African American families (Burchinal, Follmer, & Bryant, 1996). Support for mothers/female guardians was further shown to be positively associated with more adequate maternal parenting practices and with adolescent psychological well being in economically disadvantaged African-American families (Taylor, & Roberts, 1995). Overall parental functioning improved thanks to professional intervention. The psychological well being of adolescent pregnant mothers improved with intervention (Thompson & Willkins, 1992). Within the marital relationship, support can promote positive results. Support from spouses contributes to the prevention of depression and depression-like behaviors (e.g. irritability, loss of motivation, withdrawal and isolation) which negatively affect on the marital relationship (Conger, Rueter, & Elder, 1999; Cutrona, 1996). Research has also indicated that during periods of severe stress, such as economic distress, spousal support moderates the impact of depression on parental behavior (Simons, Lorenz, Wu, & Conger, 1993).

Family functioning

The family functioning theory is grounded in the general systems theory (Walsh, 1993), and is defined as a set of basic attributes about the family system that characterize and explain how a family system typically appraises, operates, and/or behaves (McCubbin & Thompson, 1991). Family functioning is associated with the multiple dimensions of marital and family dynamics such as problem solving, communication, cohesion,

growth, partnership, affection, adaptation to stress, flexibility to change, bonding, expressiveness, conflict resolution, religious emphasis, organization, sociability, external locus of control, task accomplishment, values and norms, and family rituals, to name just a few (Touliatos, Perlmutter, & Straus, 1990).

Method and Measurements

Sample and data collection

This study utilized a nonprobability, purposive sampling method. This method was chosen because of the low response rates that are associated with family research, especially in rural areas. Families whose children attended Head-Start centers in rural Southwest Virginia were targeted for participation in this study. Head Start family workers handed out a questionnaire along with a letter emphasizing participant confidentiality to those families who agreed to participate in the study. The letter also asked participants to indicate the length of time needed to complete the questionnaire, and any problems they might have encountered while answering the questions. Twenty-three completed questionnaires were returned.

All but one questionnaire were completed by women. All respondents were Caucasian (100%, $n = 23$). Fifty six percent ($n = 13$) of them were married, ranging in age from 21-44 years. Thirty percent ($n = 7$) of the respondents were single mother households and 13% of these single mothers ($n = 3$) were living with a male partner (boyfriend/fiancé). Sixty-nine and a half percent of the women had a 12th grade education ($n = 16$) and were not employed outside of their homes (69.6%). The majority of their spouses/partners (as reported by the women) had an average of 12 or more years of education (52.2%, $n = 12$) and were employed on a regular or irregular full-time basis (52.2%, $n = 12$). The average household income

was \$15,322, and most families had about 2 or more children per family. Except for one family who supported two aging relatives, no families lived with or supported others.

Measurement of study variables
Economic hardship was measured using federal poverty guidelines (above or below \$16,450 annual income for four family members). Family resiliency was measured by two different scales--the Family Hardiness Index and a measure of perceived social support. The Family Hardiness index is composed of three sub-scales: The Commitment sub-scale is an eight-item scale, which measures the family's sense of internal strengths, dependability and ability to work together. Items include such statements as "we do not feel we can survive if another problem hits us," "we strive together and help each other no matter what." The Challenge sub-scale is a six-item scale which measures the family's efforts to be innovative and active, to experience new things and to learn. Items include such statements as "we listen to each other's problems, hurts, and fears," "being active and learning new things are encouraged." The Control sub-scale is a six-item scale that measures the family's sense of being in control of rather than being shaped by outside events and circumstances. Items include such statements as "trouble results from mistakes we make," "most of the bad things that happen are due to bad luck." The overall internal reliability for the FHI for this study is .75 (Cronbach's alpha) (McCubbin, Thompson, & McCubbin, 1996).

The perceived social support scale used in this study is based on Barrerra's (1981) conceptual framework. The measure of social support as it is adapted here is a 15-item instrument that uses a 5-point Likert scales ranging from strongly disagree to strongly agree. These items reflect

the different ways in which formal and informal sources of support render assistance to the family, including emotional encouragement, advice, and guidance, tangible aid, or concrete assistance in times of need. The following are examples of items included in this scale: "I can always count on a friend or family member to loan me money when I need it," "I can always find someone to talk to when I am stressed." The overall internal reliability for this study is .73 (Cronbach's alpha).

Family functioning was measured using the McMaster Family Assessment Device (FAD) Epstein, Baldwin, & Bishop, 1981). The FAD is a self-report, 4-point Likert-type of instrument. It is comprised of six specific areas of family functioning, in addition to general functioning: Problem Solving; Communication; Roles; Affective Responsiveness; Affective Involvement; and Behavior Control (Sawin & Harrigan, 1995). The number of items per sub-scale ranges from 5-12, totaling 60 items, consisting of both positive and negative statements. The general family functioning subscale, which assesses the overall health/pathology of the family, was the measure used for assessing overall family functioning in this study. The following are examples of items included in the General Functioning sub-scale: planning family activities is difficult because we misunderstand each other; in times of crises we can turn to each other; we are able to make decisions about how to solve problems (Epstein, Baldwin, & Bishop, 1981). The internal consistency for the General Functioning Scale was .83-.86 (Cronbach's alpha) and the test retest reliability for the General Functioning was .71, (Sawin & Harrigan, 1995).

Findings

Due to missing data only seventeen responses of the possible twenty three were included. Means and standard

	Mean	Standard Deviation
Family functioning (FAD)	1.95	0.31
Income	15, 322	
Social support enacted	16.29	5.64
Family Hardiness	40.65	10.45

deviations for dependent and independent variables are detailed in Table 1.

An incremental regression analysis was performed to obtain Pearson Correlation Coefficients, and to assess the hierarchical contribution of the various models in explaining total family functioning. As Pearson Correlation Coefficients indicate, a statistically significant correlation exists between a family's hardiness and family functioning ($r = -.60, p = .005$), and a family level of social support and family functioning ($r = -.49, p = .022$). The family's income was not been shown to be significantly correlated with the level of family functioning ($r = .37, p = .07$) (It should be noted, however, that the significance level of .07 is close to statistical significance and with a sample size larger than $N = 17$, similar results would quite likely reach statistical significance).

As can be seen in Table 2, the incremental analysis indicates that the level of a family's income explains 13 percent of family functioning, while a family's resiliency (hardiness and social support together) explain 43 percent of family functioning. Family hardiness explains 28% of family functioning and social support explains the remaining 15% of family functioning. Std. Error of the Estimate and F Change for each model are detailed in Table 2.

A two-way analysis of variance was

performed to observe the influence of family structure- dual-parent family and single-parent family- on the family's perception of economic distress, family hardiness, social support, and family functioning. In order to simplify results the variable non-married couples living together, was recoded as a married couple. Results of this analysis indicate that there is no significant main effect for family's structure: dual-parent families ($M = 20.9, SD = 5.3$) did not score statistically significant higher than single-parent families ($M = 22.7, SD = 4.7$) on their perceived financial distress $F(1,21) = 6.12, p = .44$; family hardiness ($M = 112.0, SD = 18.5; M = 121.6, SD = 17.0$) $F(1,21) = 1.3, p = .26$; social support ($M = 56.4, SD = 9.9; M = 61.5, SD = 10.4$), $F(1,20) = 1.13, p = .30$; or family functioning ($M = 2.0, SD = .32; M = 1.86, SD = .35$), $F(121) = 1.04, p = .32$).

Discussion

This study examined the nature of the relationship existing between a fami-

ly's income and level of functioning, and the relationship between family resiliency (family hardiness, social support) and family functioning in those families who experience economic hardship.

Based on previous studies, living in poverty creates stress on the family and eventually has a negative effect on a family's healthy functioning (Conger, Elder, Lorenz, Conger, Simons, Whitbeck, Huck, & Melby, 1990; Voydanoff, 1991). However, as this study's results indicate this relationship does not hold true when family resiliency is taken into consideration.

Family resiliency on the other hand, confirmed other studies' findings. Namely, as most studies demonstrate there is a positive relationship between family resiliency and healthy family functioning (Taylor, & Roberts, 1995). However, by explaining almost twice as much variance in family functioning as social support, family hardiness emerged as having a vital role in healthy family functioning. The more the family perceives itself as having a strong sense of internal strength, dependability and ability to work together, the better its functioning. This finding is congruent with other studies, which have identified the positive effect that family resiliency has on family functioning in times of stress (Conger, Rueter, & Elder, 1999; Taylor & Roberts, 1995;

Model	R	R ²	R ² change	Std. Error	F Change
1- family income	.366	.134	.34	.29	2.32
2- Family Hardiness	.643	.414	.280	.25	6.68*
3- Social Support	.752	.565	.152	.22	4.54*

• $p < .05$
 • Model 1-Predictors: (Constant), Family Income; Model 2- Predictors: (Constant), Family Income, Total Family-Hardiness Score; Model 3- Predictors: (Constant), Family Income, Family-Hardiness, Social Support.

Thompson, McCubbin, Thompson, & Elver, 1995; Thompson, & Wilkins, 1992).

Because this study sample consisted of dual-parent families and single-parent families it was interesting to compare these family arrangements. The two groups were compared in relation to their perception of economic distress, their family hardiness, perception of social support available to them in time of need, and their family functioning. Results demonstrate that there is no statistically significant difference between the two groups. However, a closer scrutiny of test results demonstrate that single-parent families score slightly higher in family resiliency, informal social support, and lower in family functioning. These findings are similar to the results found in the Hawaiian study which compared dual and single-parent families living in poverty in relation to their social support and family strengths (Thompson, McCubbin, Thompson, & Elver, 1995). These results imply that when families are poor being single or living with a partner makes no difference. When parents cannot afford to provide for their children a life of comfort, they are stressed. Just like Thompson's et al. (1995) and Coutrona's (1996) results demonstrate that single mothers tend to turn to their family, friends and other sources of informal support in times of need while married couples lean on each other.

This study has further set out to answer the question if resiliency resources matter in the functioning of families with low incomes. Relying on this study's results and based on the theoretical framework underlying this study, it may be concluded that family resiliency does matter in the healthy functioning of poor families. This study indicates that family resiliency (family hardiness and social support together) is not only significantly related to healthy family functioning, but it also explains 43 percent of a family's functioning. Thus, it can also be con-

cluded that resiliency has a buffering effect on the stress experienced by this segment of the population.

Limitation: Sample size, cultural considerations, and measurement scales

Although this study has produced some interesting results, its small sample and non-randomization reduce its power for generalizability beyond this study's participants. In explaining the low response rate, three major factors have been identified. The first is related to the length of the questionnaire. All study participants are parents of young children and find it hard to secure special time for extra duties unrelated to family life and house chores. Those respondents who completed the questionnaire spent about 45 minutes (at time over two evenings). The second problem associated with the questionnaires is their suitability to traditional nuclear families. Some of the single-parent respondents noted that they were unable to answer the questions because they applied to two-parent families. The last issue relates to the participants' culture. People in the rural parts of Southwest Virginia are known to be private people. Most of this study's questions are geared towards finding information on family life and at times are invading people's privacy. Several respondents who declined to complete their questionnaires cited invasion of privacy as the main reason. The above factors are important to consider when conducting studies involving families.

Implications for social work practice

This study is important to social work practice. It contributes to expanding our understanding of family functioning and the role that family resiliency plays in it especially with those who strive to maintain healthy family functioning in the face of economic hardship. By realizing the important role that resiliency has on poor people's lives, social worker can introduce

interventions in both the individual and community level that are strengths based and prevention oriented. For example, social workers are in key positions to initiate community programs such as ride sharing to insure that people do not lose work and income due to unreliable transportation. They may also initiate workshops on family resiliency and healthy family functioning. Doing so will provide our clients with ideas and models that they might want to adapt and will enrich their repertoire of techniques they can use in dealing with family stress. Social workers can also help clients in the individual level. People can be so overwhelmed in times of stress that relying on their own strengths may be too scary. When social workers help clients identify those innate strengths that helped them overcome stress in the past, they empower them and teach them a skill for life. Such skills may include supporting a family member or a friend in times of need, volunteering for a worthy cause, or overcoming past abuse to become a strong mother to her children. When a person realizes that they possess the strengths needed to overcome challenges, their self-image changes. They begin viewing themselves as capable. They realize that change is not danger, but rather a challenge and an opportunity. Change is stressful, but at the same time presents hope for a future that is more congruent with their dreams. Families, like individuals, may recollect the times when they stood together behind a sick child or a struggling family member, or helped their community recover from a natural disaster like flood or fire, or a man-made disaster like homicide. While reflecting on such times, families too realize that by working together and supporting each other they can gain control over the circumstances of their lives. Social workers can further provide their clients with examples of individuals or families who faced similar conditions and suc-

ceeded in establishing a satisfying life for themselves and their children. When a person realizes that he/she is not alone in facing hardship, and others who faced such conditions succeeded, they gain the courage to learn new skills and follow in the footsteps of their predecessors.

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NARMH BOARD OF DIRECTORS ELECTION ANNOUNCEMENT

NARMH is currently soliciting committed individuals to run for the Board of Directors. Terms of office are for three years. To serve on the NARMH Board, an individual must meet several requirements. These include:

1. You must be an individual member in good standing for one full year or longer.
2. You must be willing to travel, at your own expense, to the two Board of Director's meetings each year. The winter meeting occurs over a three day period and is typically held in Washington DC. The summer Board Meeting occurs as part of the annual conference.
3. You must be willing to devote time each week, to NARMH activities. These activities include, but may not be limited to committee assignments, special projects, writing articles, doing work on-line.
4. You should have access to e-mail since most ongoing NARMH business is conducted on-line.

If you wish to submit your name for membership consideration, please mail the following information to the NARMH Office *no later than April 7, 2003*:

- 1) Name, address, phone, fax and e-mail.
- 2) Brief biographical sketch and statement of what you feel you can bring to the organization as a board member (not to exceed 100 words).

If you have any questions about the positions, the commitment or time required to serve in this capacity, please contact, David Lambert, Nominations Chair at (207) 780-4502, email davidl@usm.maine.edu, fax (320) 202-1833 or call the NARMH office at (320) 202-1820.

*David Lambert
Nominations Committee Chairperson*

National Strategy Seeks To Prevent Suicide

Article reprinted from SAMHSA News, the official newsletter of the Substance Abuse and Mental Health Services Administration, Volume X, No. 4, Fall 2002.

by Marilyn Dickey

Terri Ann Weyrauch, M.D., seemed to have everything. She was a bright, beautiful young woman, board certified in internal medicine and rheumatology, and in private practice in Chicago. But she suffered from depression. Despite the fact that she was doing all the right things—seeing a psychiatrist and taking medication—she took her own life in 1987, at the age of 34.



Elsie and Gerald Weyrauch of Marietta, GA, turned their personal grief into public action by starting the nonprofit group called the Suicide Prevention Action Network to bring the issue to the forefront of national attention. They are holding a "memory quilt" containing a photo of their daughter, Terri.

Photo by Ralph Dantiel

To reduce the occurrence of such tragedies, the Federal Government launched the National Strategy for Suicide Prevention in May 2001. It is a massive effort, spanning several Federal agencies (including SAMHSA), state governments, nonprofit organizations, communities, and others. Since the strategy's release, numerous activities have been initiated in support of its goals.

"Even one death by suicide is one death too many," says SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., noting that more than 90 percent of suicides are associated with mental illness. "Most suicides are preventable. We need to raise awareness that help is available, treatment is effective, and recovery is possible."

Convergence of Efforts

Suicide is a far more common problem than many people realize: For every two homicides in this country, there are three suicides. For every person who dies from HIV/AIDS, two people die by suicide. Every year nearly 30,000 people lose their lives to suicide and 650,000 attempt suicide. Suicide is a tragedy that has touched the lives of countless survivors—those who live on after a relative, friend, neighbor, or colleague takes his or her life.



Only recently have efforts to understand and prevent suicide coalesced into a united movement. When Terri Ann Weyrauch ended her life, her parents, Gerald H. Weyrauch, M.B.A., and Elsie Weyrauch, R.N., of Marietta, GA, turned their grief into action. In 1996, they started a nonprofit group called the Suicide Prevention Action Network (SPANUSA) to bring more attention to the issue and act as "a catalyst, a conscience, and a prod to action," in Gerald Weyrauch's words.

Elsie Weyrauch explains, "The people who formed SPANUSA wanted to empower survivors—those close to someone who committed suicide as well as suicide attempt survivors—by helping them make a difference. The World Health Organization's 1996 document, *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*, suggested steps we could take to push for development of a national suicide prevention strategy and helped us come together as a grassroots advocacy organization." SPANUSA provided the impetus for the formation of an innovative public/private partnership that sponsored a National Suicide Prevention Conference in Reno, NV, in 1998. Participants assembled a list of 81 recommendations that were presented to the U.S. Surgeon General. SPANUSA also collaborated with several other nonprofit groups to form the National Council for Suicide Prevention in 1999, aimed at bringing the issue to the forefront of national attention.

In 1997, galvanized by the memory of his own father's suicide, U.S. Senator Harry Reid (D-NV) took the lead in persuading the Senate to pass a resolution calling for action on the issue. A similar resolution passed in the U.S. House of Representatives in 1998.

In 1999, the U.S. Surgeon General's office issued a brief report, *The Surgeon General's Call to Action to Prevent Suicide*, based on key recommendations made at the Reno Conference.

Six Federal agencies, including SAMHSA, provided funding in the year 2000 to the Institute of Medicine to assess scientific information on the causes of suicide and to recommend strategies to prevent it. The report was published in 2002.

One of the most significant developments was the 2001 release of the *National Strategy for Suicide Prevention*. Prepared by a group of public and private sector partners with leadership and support from the Surgeon General, it has guided many of SAMHSA's efforts in this area. In designing the *National Strategy*, a Federal Steering Group assisted by the National Council for Suicide Prevention and others, created 11 goals and 68 objectives for preventing suicide. These range from promoting awareness that suicide is preventable to improving access to mental health services to reducing the stigma of mental illness and substance abuse.

The *National Strategy* aims to provide better resources for people—in all age groups, every region of the country, and all walks of life—dealing with the physical, emotional, and other conditions that can lead to suicide. It also aims to support people whose loved ones died by suicide, reduce the stigma attached to mental illness, and improve the coverage of mental illness, drug addiction, and suicide in the media.

"As we were developing the *National Strategy*, it became quite clear that public health efforts like this need to have a broad coalition involved in their implementation," says Col. David A. Litts, O.D., Special Adviser to the Surgeon General for suicide prevention. "No single entity or group can carry these things off alone."

A number of states are moving ahead to develop or implement their own suicide-prevention plans, adds Dr. Litts. "Many are literally lifting the words out of the National Strategy, using the National Strategy as their guide to implementing their state plans," he says.

SAMHSA's Contributions

The Federal Steering Committee overseeing the National Strategy includes representatives from SAMHSA, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the National Institutes of Health, and the Office of the Surgeon General. Each Federal agency is contributing expertise. For example, the National Institutes of Health conducts research into the causes of suicide; the Centers for Disease Control and Prevention tracks the incidence of suicide and collects statistics. SAMHSA likewise has a unique role.

"SAMHSA acts as the link between the Federal effort, states, and local communities," says Gail Hutchings, M.P.A., Acting Director of SAMHSA's Center for Mental Health Services. "By providing resources, funding programs, and evaluating the results, SAMHSA serves as a key connection to the Federal Government for stakeholders seeking to prevent and reduce the incidence of suicide." A SAMHSA grant of \$2.5 million was awarded this fall to create a National Suicide Prevention Technical Resource Center to provide information and other help for clinicians, researchers, survivors, advocates, local and state governments, and tribal organizations. The Education Development Center in Newton, MA, received the funding for 3 years to collaborate with the American Association of Suicidology, the American Foundation for Suicide Prevention, and the Suicide Prevention Action Network on the effort.

SAMHSA awarded another grant, for \$9 million, 1 year ago. In the first year of this 3-year grant, the American Association of Suicidology has been working on ways to improve access to crisis centers and hotlines. Lanny Berman, Ph.D., Executive Director of the association, has three goals: to improve the quality of crisis hotlines across the country, to establish one nationwide number to connect callers with the hotline nearest them, and to build in a system of evaluation to see if hotline services are effective.

The national hotline (1-800-SUICIDE) is already up and running and adding crisis centers to its roster all the time. The goal is to have between 200 and 300 hotlines in the network by the end of the grant period. "If you don't have a center listed in your phone book and you're in a crisis—and you want to call what in effect is a 911 number—you can call this number and it would route your call to the nearest hotline," he says.

One goal of the grant is to urge more hotline and crisis centers to take advantage of a certification program that the organization established more than 20 years ago. Certification, says Dr. Berman, "is a statement to their community that these centers have policies, processes, training, and quality of service that the community can trust."

In addition to the grants, SAMHSA is developing suicide-prevention guidelines for schools based on a model called the Youth Suicide Prevention Strategy developed in New Zealand. The guidelines are being designed to identify students at risk for suicide and to promote a safe, comfortable environment where they can seek and receive help. The goal is to provide a useful tool to school personnel (including teachers), to help them establish evidence-based programs in their facilities.

Another program is the Signs of Suicide Evaluation project, started by a nonprofit group called Screening for

Mental Health. This project also targets schools, in particular high school students. During the 2000-2001 school year, 220 high schools participated in a screening for depression and suicidal behavior among students. As part of the program, teens learned about depression and how to recognize it in their peers. Funding from SAMHSA is allowing the organization to take a detailed look at how much teens learned from the program and evaluate its effect on students' suicidal behaviors.

As various efforts are mobilizing, Lloyd B. Potter, Ph.D., M.P.H., Associate Director of the Center for Violence and Injury Prevention at the Newton, MA, Education Development Center, has taken on the job of developing baseline data as a way eventually of measuring whether the National Strategy's goals and objectives are achieved. That means finding ways of measuring everything from increasing the number of states with suicide prevention plans to promoting research on suicide prevention to providing training to medical personnel, clergy, and teachers—and much more.

Crucial to the success of the National Strategy, says Robert E. DeMartino, M.D., who, as SAMHSA's Associate Director of the Program in Trauma and Terrorism, oversees the Agency's suicide prevention efforts, "is a willingness on the part of all of the players to function as one unit, with one goal: to save lives. We have to keep speaking with one voice."

For more information, contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647) or 1 (866) 889-2647 (TTY). Or, visit the National Strategy for Suicide Prevention at www.mentalhealth.samhsa.gov/suicideprevention.

EarthPrayers

by Robert Johnson

My Earthwork has evolved over the past 9 years to include the public in the planning, as well as the construction of sculptures, monuments, or sacred celebratory objects.

The story begins with my back going into spasms while working at a mental health center. The managed care system profits has destroyed community mental health in America, slowly starving the mental health centers out of business. The mental health centers often have little regard for clients or staff as they do what they can do to survive. I was completely stressed with too many clients and constant “productivity quotas” as if I was flipping burgers instead of working with people’s souls.

While nursing my back and trying to understand the pains meaning, I saw a flyer for building with Cob, it was something I didn’t know what I was going to do with, but it was something I couldn’t not do! So I went to The Cob Cottage people in Cottage Grove Oregon to learn about Building with Cob. It changed my life! The week-long workshop is kind of a boot camp of building with earth, teaching all of the essentials of building with Cob.

When I got back to Whidbey Island where I was living, I resigned from my position. And began building my first Earth sculpture “Sophia the Raven. She was 5ft tall and weighed 400 lbs. (Cob is 10 to 30% clay, straw, sand, water and love) A few months later after some environmental destruction on the Island (or one of our never ending wars), I decided to gather some friends and create An Earth Prayer for Peace. What happened though, is people started calling wanting to be part of the project, and before we were through, 33 people had been part of

the project. I actually had to slow the process down to accommodate the amount of people who wanted to mix mud with their feet and hand build the monument. People would actually stop their cars and ask us what we were doing, and then ask if they could help (sometimes in their Sunday best clothes). People started bringing objects to imbed in the sculpture that meant peace to them; a piece of the Berlin Wall, crystals and pendants, prayers and poems and even the ashes of a loved one. People also began leaving flowers at the edge of the fence and lighting candles, even before they knew what it was. The power of the Earth is awesome! And so began the process of building community collaborative Earth sculptures, Homes or other sacred objects, called “Earthprayers”.

I believe that as a people we are living our lives out of balance with the non-human world. Most Americans spend 70 to 75% of our lives indoors (on concrete or asphalt) and have forgotten the importance of the natural world to our peace and sanity. Carl Jung believed that our Souls extended into the natural world around us, so that hurting the environment is actually doing violence to our own being. As an Ecological Psycho therapist I believe further that we are suffering from an attachment disorder to the Earth, as our child development models do not recognize the importance of a connection to the natural world as



being important; we’ve forgotten how to be human.

The Scientific beliefs of the mind/body/ environment split further exacerbate the pathology of our thinking (and living) as a culture.

While building An EarthPrayer for Peace, a principal from an alternative high school participated. She was so moved by the process that she asked me to do a project at her school. We received a grant from A Territorial Resource to construct “Earthway Archway”(designed by the students) with benches that lead into their organic garden. The grant was written with the idea that schools could no longer be separate from their communities and the Earthwork embodied

that idea by having over a hundred people from the community mix mud and help complete this student /community EarthPrayer. The school got many new volunteers and actually set up a business of selling their organic produce at a farmers market, with help from the community of people who came forward to work on the project.

I moved back to Santa Fe a year later and started doing projects here. I facilitated over 140 children (and some parents) in creating an interactive EarthMother sculpture at the Santa Fe Children's Museum over the course of three weeks. She stands 9 feet tall and five feet in circumference, standing on a beautiful stone base.

A few weeks later as part of an interfaith Mud day celebration, in collaboration with horticultural artist, Kevin Avants, (who laid out the 75ftx75ft Hopi Mother Labyrinths) I helped facilitate and teach the Cob process to the 75 to 100 people who managed to construct this magical labyrinth in one day.

I enjoy meeting people to serve their needs and the needs of community (an endangered species) in creating meaningful community art, or practical sacred objects or buildings. The coarseness of the material often causes people to let go of fears about art and become more playful in their approach to the project. The process is a potent force in bringing Peace and I would like to work in conflictual "Hot Spots" to let the Earth be part of the Healing. A friend recently told me that when a group of environmentalists and ranchers got on the Land together, their conflicts were solved in an amazingly easy way.

Other pieces I've done with people include, a Dragon parapet, Tortoise bench and Mermaid buttress for a children's playhouse. I have also helped construct a number of art themed benches, A Peace bench at a

Montessori school, (started on the week of 9-11-02) A Heart bench at Peace Prayer Day, a Siek gathering in Espanola New Mexico each summer (as part of plans for a Peace Park on the land) And two years ago at Ghost Ranch in northern New Mexico as part of a workshop I do "Healing the Earth Healing Ourselves" we constructed La Pacha Mama A beautiful figurative earth Mother (designed by artist Gerri Gosset and changed by the process of collaboration) that 20 to 25 women worked on, and every woman who worked on her cried. Most said they didn't have words to describe the tears of this profound experience. I believe we are all suffering from the deep trauma of living in such a violent culture, and as one of the lines of one of my poems suggest "grieve and make love grieve and make love" as an antidote to the violence.

I am now doing trainings in Ecological Psychology for schools, treatment programs, businesses and professional organizations and include experiential components, from meditating with lit-

tle" Earths" (earth balls) or whenever possible to get people to mix the mud with their feet and work together to build something beautiful (it changes lives). We are starved for experiential knowledge in our abstract book information focused educational system. The process of Cob building teaches the values of playful non-hierarchical cooperation, spirituality, and fun.

Robert Francis Johnson M.S. is a licensed Professional Counselor specializing in Ecological Psychology, a licensed teacher who weaves environmental education into all his work. A published poet and writer, and an Environmental Artist who brings people together to play, heal and dance in the beauty of the Earth, constructing community as part of the process of creating, "EarthPrayers". He also has stone and ceramic sculptures in major galleries in the western United States. He can be reached at Po Box 2791 Santa Fe N. M. 87504 (505) 954-4495 earth-prayers@hotmail.com



President's Commission Reports "Mental Health System Is in Disarray"

Article reprinted from SAMHSA News, the official newsletter of the Substance Abuse and Mental Health Services Administration, Volume X, No. 4, Fall 2002.

Calling the mental health system an inefficient maze of private, Federal, state, and local government programs with scattered responsibility for services that frustrates both people with mental illness and providers of care, the President's New Freedom Commission on Mental Health Chairman Michael F. Hogan, Ph.D., released an interim report to the President this fall.

Citing the need for dramatic reform at all levels of service delivery, Dr. Hogan said, "the Commission's challenge now is to identify realistic solutions to help people with mental illness get the quality care that research has shown to be effective."

The Commission is charged with conducting a comprehensive study of the U.S. mental health service delivery system and advising the President on methods of improving the system to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. (See SAMHSA News, spring 2002.) As part of that goal, President George W. Bush's April 29, 2002, Executive Order creating the Commission requires this interim report to describe barriers to the delivery of effective mental health care. The report also provides examples of community-based care models that show success in coordinating services and providing desired outcomes.

"Today, people diagnosed with cancer or heart disease benefit from a broad array of effective treatments," Dr.

Hogan continued. "People with mental illness deserve no less. Undetected, untreated and poorly treated mental disorders interrupt lives, leading many to disability, poverty, and long-term dependence. The good news is that recovery from mental illness is a reality; a range of safe and effective treatments, services, and supports exist for men, women, and children with mental illness. We know that when mental illness is diagnosed early and treated appropriately, quality of life is tremendously improved. Yet, half of all people who need treatment for mental illness do not receive it. The rate is even lower for racial and ethnic minorities, and the quality of care they receive is poorer."

In its report, the Commission identified barriers to quality care and recovery. Some barriers relate directly to the service delivery system itself, such as fragmentation and gaps in care for children, adults, and older adults. Others encourage dependency through



The President's New Freedom
Commission on Mental Health

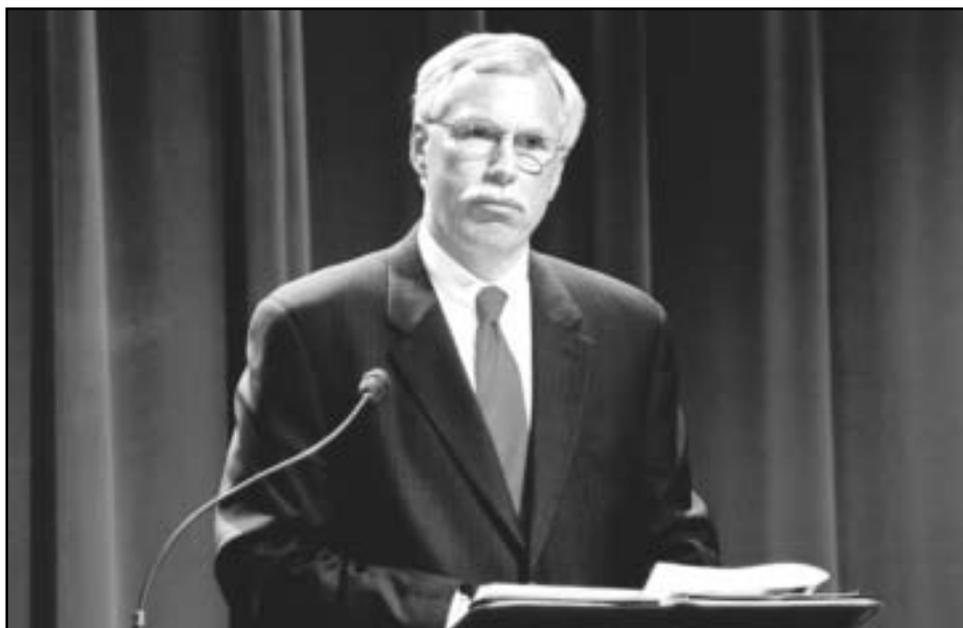
INTERIM REPORT TO THE PRESIDENT

October 29, 2002

Presented to:
The President's
New Freedom Commission
on Mental Health

a mix of inadequate rehabilitation services and disincentives to work. Still others reflect a failure to make mental health a national priority. In its next phase of work, the Commission will be addressing ways to break down these barriers to recovery.

Dr. Hogan said, "We need to answer the question, 'Why are 90 percent of adults with serious mental illness unemployed?' After all, studies show that a majority want to work and can work. Instead, our Nation's largest



Michael Hogan, Chairman of the President's New Freedom Commission on Mental Health, presented findings from the Commission's Interim Report, now available online.



'program' for people with mental illness is the disability system. Our mental health, rehabilitation, and disability programs unintentionally trap millions of individuals—who want to work—into expensive, long-term dependency."

Dr. Hogan continued, "The barriers that keep adults with mental illness from productive work and children with serious emotional disturbance from school success are a tragedy from both human and economic perspectives. Although most adults with mental illness want to work, they are the largest and fastest growing group of people with disabilities receiving Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) payments. An estimated \$25 billion is spent annually for this population."

He added, "Many people with mental illness find that they cannot afford to go back to work because they would lose their Medicaid coverage and disability benefits, and despite a job, could not afford private health insurance coverage. Too many people with mental illness are trapped in a 'disability welfare system' that badly serves them and needs reform. And although many children with emotional disorders are very bright, fewer than half ever graduate from high school. Our failure to support employment and school success is a disgrace."

To help identify what works best to provide care for people with mental illness, the Commission has already identified some creative, community-based programs that blend the promise of modern science with the compassion of skilled professionals. These exemplary programs often achieve the best results, despite bureaucracies that frequently create fragmentation instead of focus, and that reward dependency instead of recovery. They range from school-based mental health care in Dallas, to home visits by trained nurses for high-risk women during pregnancy and the first year of their child's life, to suicide prevention by the U.S. Air Force, and effective treatment for late-life depression.

"These models," Dr. Hogan said, "can inspire communities nationwide and provide realistic examples of how quality, coordinated care is possible for the millions of Americans with mental illness."

Overall, the Commission's interim report found that the system is not oriented to the single most important goal of the people it serves—the hope of recovery. Many more individuals could recover—from even the most serious mental illnesses—if they had access to effective treatments tailored to their needs, and to supports and services in their communities. State-of-the-art treatments, based on decades of scientific inquiry, are not being transferred from research to community settings. At the same time, many outdated and ineffective treatments are still used.

The President tasked the Commission to recommend improvements in the mental health service system and requested a review of both public and private sectors to identify policies that could be implemented by Federal, state, and local governments to maximize the utility of existing resources, improve coordination of treatments



and services, and promote a full life in the community for people with mental illness. The Commission's recommendations will be presented in its final report. The document released this fall responds to the legal requirement for an interim report. The Commission's work is essential to the President's commitment—embodied in the New Freedom Initiative—to eliminate inequality for Americans with disabilities.

For a printed copy of the Interim Report to the President, contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). For information about the Commission and an electronic copy of the report, visit www.MentalHealthCommission.gov.

"Today, people diagnosed with cancer or heart disease benefit from a broad array of effective treatments. People with mental illness deserve no less,"

Michael Hogan

Preliminary Analysis of New Bush Proposal to Block-Grant Medicaid

On Friday, January 31, 2003, HHS Secretary Thompson unveiled a new proposal from the Bush Administration to radically restructure the Medicaid program. Although the proposal, called the “State Health Care Partnership Allotments,” has been characterized by the Administration as a way for states to preserve and expand health coverage for their most vulnerable residents, it is very likely to result in reduced access to health care for low-income people.

In fact, this plan takes advantage of the states’ dire fiscal situation and their real need for federal aid to further the Administration’s goal of undermining the Medicaid entitlement. Should Congress approve this plan, states will be forced to accept what is, in essence, a block-granting of Medicaid in order to obtain any fiscal relief from the federal government. While there are still many unanswered questions about the plan, this document summarizes the skeletal information that we have now. To see the Administration’s press release announcing the plan, go to (www.hhs.gov/news/press/2003pres/20030131d.html).

What is the Administration’s plan?

The Administration proposes to offer states \$12.7 billion in additional Medicaid funds from 2004 to 2010. States would be offered as much as \$3.25 billion in 2004. States that agree to accept these funds will receive all of their Medicaid and SCHIP funds thereafter as a combined block grant. The block grant will consist of two allotments: one for acute care and one for long-term care. States will be allowed to transfer a small amount of money (10 percent) between allotments. The amount of a state’s allotment will be based on its

expenditures in fiscal year 2002. States will be required to maintain a financial commitment to Medicaid and SCHIP based on their expenditures in fiscal year 2002. Under the block grant, states will have broad authority to change the scope of coverage for optional Medicaid and SCHIP beneficiaries without a waiver from the federal government—although there will be some (as yet unspecified) minimum requirement for coverage of mandatory Medicaid beneficiaries.

States that decide against going this route will continue to operate their traditional Medicaid and SCHIP programs, but they will not receive any federal fiscal relief.

Does the proposal provide additional money to states?

No. Although the proposal advances \$12.7 billion of Medicaid funds to states over the next seven years, it is designed to be budget-neutral over 10 years. That means that states will receive smaller allotments in 2011, 2012, and 2013 to repay the \$12.7 billion they received earlier. But even beyond 2013, states that accept this deal are likely to receive less money than they would have received with traditional Medicaid funding. Under a block grant, states will be constrained in their ability to respond to increased demand for Medicaid in the case of a future economic downturn, growing populations, or increased health care needs due to the aging of the baby boom generation, for example.

How will the plan affect beneficiaries?

The plan treats mandatory beneficiaries differently than optional beneficiaries and other individuals that a state may choose to cover (CMS has referred to these as “expansion” beneficiaries in the context of HIFA waivers). Under the plan, mandatory beneficiaries are provided some protection: states will be required to provide a minimum benefit package for mandatory beneficiaries and will still be required to cover mandatory beneficiaries. The minimum benefit package for mandatory beneficiaries is described as “comprehensive” by the Administration, but no specifics have been offered.

The plan could eliminate the Medicaid entitlement for the nearly 12 million optional beneficiaries currently enrolled in Medicaid. Under the new structure, states would apparently have free rein to decide eligibility levels, enrollment limits, benefit structure, and cost-sharing rules for optional and other beneficiaries without a waiver from the federal government. State Medicaid expenditures for optional beneficiaries and optional services are nearly two-thirds of all Medicaid spending and accounted for some \$100 billion in fiscal year 2001. The proposal puts access to health care at risk for optional beneficiaries, including 100 percent of children enrolled in SCHIP, 56 percent of seniors, 22 percent of people with disabilities, 43 percent of parents, and 20 percent of children enrolled in Medicaid.

¹ See “What’s At Risk In State Medicaid Programs?” for more information about mandatory and optional beneficiaries and services, available online at (www.familiesusa.org/Action%20Kit%20State%20Advocates/2003/1b_What%27sAtRisk.pdf).

² Kaiser Commission on Medicaid and the Uninsured, *Summary of “Mandatory” and “Optional” Eligibility and Benefits*, available online at (www.kff.org/content/2003/20030131/4002.pdf).

³ Ibid.

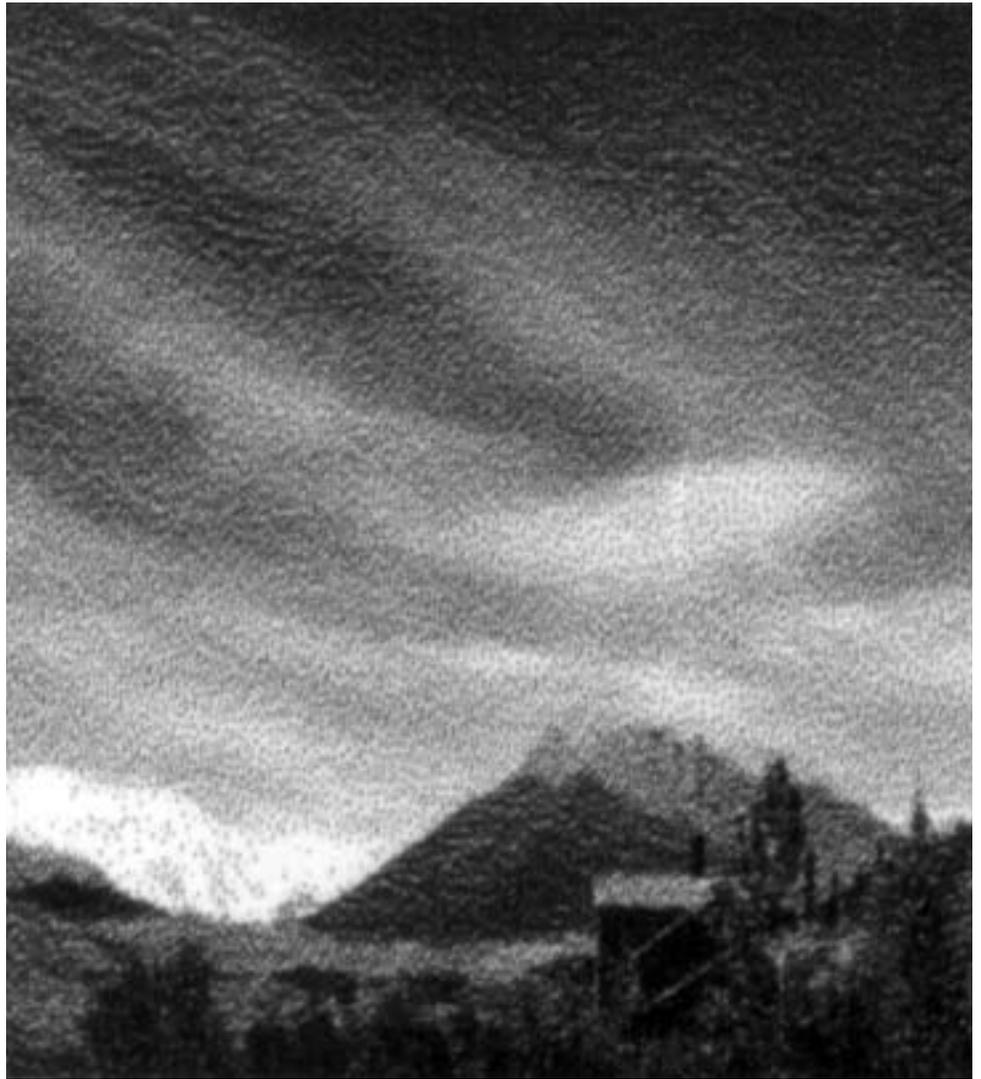
⁴ Ibid.

⁵ S. 138, introduced in the 108th Congress by Senators Rockefeller (D-WV), Collins (R-ME), and Nelson (R-NE). The House bill, sponsored by Representatives King (R-NY) and Brown (D-OH) has not yet been introduced.

Will more people receive health coverage through this plan?

It is unlikely that this plan will significantly increase access to health care for the uninsured. In fact, this proposal could increase the number of uninsured. States that decide to accept this fiscal relief will use it as just that—fiscal relief for shortfalls they are encountering, not as new funds to support health coverage expansions. What is more, because states will receive less money in fiscal years 2011 to 2013 than they are projected to need in those years, this plan increases the pressure for states to reduce coverage for low-income people.

The amount of money proposed in this plan falls far short of what's needed to fill state Medicaid budget gaps. By contrast, some Members of Congress are considering much more significant assistance to the states. Bipartisan legislation currently pending in the Senate would provide states \$10 billion over 18 months, while legislation that will soon be submitted in the House offers states \$8 billion over 12 months. The Administration's \$3.25 billion over 12 months, with an additional \$9.5 billion over the next six years, pales in comparison. Moreover, the congressional plans would not reduce the amount of federal funds that states receive in later years in order to make up for the financial assistance they are provided. States need immediate, true fiscal relief through a temporary increase in the federal share of Medicaid payments without strings attached that jeopardize the health care of vulnerable people.



Board Member Attends NIMH Conference in Alaska

by Donald Sawyer

From August 8 through August 11, 1999, I was fortunate to attend a conference sponsored by the National Institute of Mental Health in Anchorage, Alaska, as NARMH's designated representative. The conference was sponsored by NIMH in response to the fact that as the NIMH Director Steve Hyman, MD indicated, little research money is expended on rural and frontier issues, and on Alaskan issues in particular (note: the NIMH 1999 budget was \$855 million). In fact, relatively little is known about frontier issues. Dr. Hyman pointed out that the nearly 60 million Americans living in rural

and frontier areas have the same kinds of mental health problems and needs for services as individuals who live in urban and suburban areas and that among rural populations, the prevalence of mental illness, substance abuse and disability due to these problems is equal to or greater than in urban areas. In addition, rural and frontier areas have unique characteristics that present barriers to mental health care. Access to and availability of mental health specialists are seriously lacking. Poverty, geographic isolation and cultural differences further hinder the amount and quality of mental health care available to people in rural areas.

As you can well imagine, Alaska is a beautiful state. One is truly affected by the size, expanse and wildlife that is all around. Anchorage, where the conference was based, is home to several wild moose, the occasional wolf, and to a third of the people who live in the state. As part of the frontier experience, select conference participants were airlifted to remote villages to discuss mental health needs with those providing and receiving services. My personal adventure began at 5 AM on August 9th with a flight from Anchorage to Bethel, a city 400 miles northwest of Anchorage, with approximately 6000 inhabitants, 12 miles of roads, and with only 20% of the homes hooked to sewer and water.

Descending to the airport I was struck by the beauty of the tundra, already into its "fall" colors. With thousands of lakes and ponds, 2 main rivers, and hundreds of tributaries, it is truly a remote and inaccessible area. There we visited the Yukon-Kuskokwin Health Corporation (YKHC), the regional provider of health care and mental health care services. The regional hospital, based in Bethel, served 58 small villages with a population of approximately 19,000 spread across an 80,000 square mile area. The hospital serves all 58 villages through a variety of means. In larger villages, there is often a mental health paraprofessional who provides the frontline services. Local law enforcement and police stations serve both a public safety and patient safety function by holding those who are most seriously mentally ill until transport to Bethel can be arranged. No village is connected to Bethel by road. Boats are used when the rivers are open, 4 wheel drive and snow machines are used on river beds when they are frozen, and bush planes (the local equivalent of taxis) are used in spring and fall. Interestingly, the use of telepsychiatry is quite limited due to the extremely high costs of telecommunication, for example, a regu-

lar/residential phone line costs \$900 per month since it must be connected via satellite to any village other than their own.

I visited small out-villages by boat and would like to relate my experiences at Kwethluk. Kwethluk is about 20 miles by boat from Bethel. I was in a group of 5 which included Steve Hyman and was guided by Ray Watson, a YKHC paraprofessional. At Kwethluk we met with Guy D. Guy, the YKHC alcoholism counselor who lived and worked in the village. Before we talked about mental health services, there was a cultural expectation that we meet with the traditional Chief, Joe Guy to seek his permission to visit and talk. Our guide offered condolences from our group for Kwethluk's most recent loss, a 3 year old who died as result of a sled dog attack 4 days before. This was the second loss in 6 months of a toddler to such an accident. Chief Guy acknowledged our concern by stating, "where people have a culture where they use dogs, this is to be expected". He then gathered together village leaders, the elected mayor and Chief of Police to discuss mental health issues. Like much of frontier Alaska, Kwethluk experiences a high rate of mortality associated with accidental deaths of all types, substance abuse, and suicide. Suicide is a particular problem, especially with youth. A Native Alaskan teenager is 9 times more likely to commit suicide than their lower 48 counterparts. At times, this is associated with the extensive substance abuse issues facing the young including drugs, alcohol and inhalant abuse. As you can well imagine, the formal conference sessions I later attended in the "Captain Cook Hotel and Conference Center" in Anchorage, paled by comparison, to the personal challenges of those living in the Yukon Delta, and the work being carried out by YKHC staff.

During the subsequent days at the conference, I did hear many excellent presentations on substance abuse, frontier treatment models, suicide prevention programs, child and adolescent mental health services, culturally relevant care in frontier areas, and telepsychiatry programs. NIMH Director Hyman made a commitment to additional funding for frontier research, particularly projects looking at issues in the Alaskan Frontier. Dr. Hyman also indicated a willingness to consider projects which would be less "formal" than the typical NIMH effort. It is my hope that he will carry through on his promise to increase federal funding for research in frontier areas and that NARMH can be part of this effort.

"A Native Alaskan teenager is 9 times more likely to commit suicide than their lower 48 counterparts. At times, this is associated with the extensive substance abuse issues facing the young, including drugs, alcohol and inhalant abuse."



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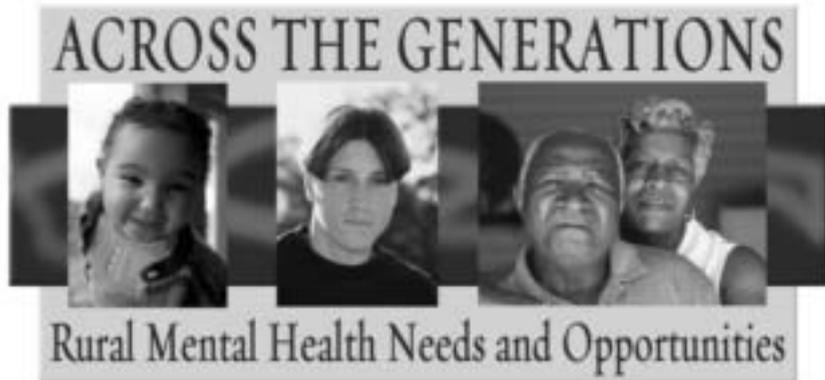
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