



# Rural Community Mental Health

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## Enhancing the Preparation of Social Workers for Rural Mental Health Settings through a Public/Academic Consortium

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There is a generally recognized need in rural mental health for better prepared service delivery professionals in all disciplines, including social work. Officials in rural mental health systems often find it difficult to recruit graduates who possess the knowledge, skills, and attitudes needed for optimally effective professional practice. They often proclaim that the academic programs that prepare these practitioners are out of touch with the needs of the real world of mental health practice in rural settings. Furthermore, they feel frustrated in their attempts to bring about curriculum changes in these academic programs to make them more responsive to the needs of rural mental health agencies.

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On the other side, academicians find it difficult to respond to the particular requirements of the numerous organizations in which their graduates will work. They tend to be jealous over their right to determine curriculum based upon multiple factors, including not only the needs of the field, but also newly-developed knowledge. Academicians also recognize that curriculum change is a slow process, whereas practitioners often want academic changes to occur in a hurry.

In order to improve the level of collaboration between the State's mental health and academic systems, the South Carolina Public-Academic Mental Health Consortium (SCPAMHC) was formed in November 1990. As a result of the creation of this organization, the academic preparation of graduate level social workers for mental health positions in South Carolina has been markedly enhanced.

### South Carolina Public-Academic Mental Health Consortium (SCPAMHC)

The South Carolina Public-Academic Mental Health Consortium (SCPAMHC) is a membership organization which includes 15 graduate level academic programs within seven colleges and universities, four consumer and advocacy organizations, and the South Carolina Area Health Education Consortium. The Consortium membership also includes a number of individuals from the South Carolina Department of Mental Health who represent various community services and programs, state hospital services, and central office administration. The consortium meets quarterly and operates through six subcommittees: Executive, Education, Continuing Education, Evaluation, Research, and Employee Satisfaction and Productivity.

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## **Mission of the Consortium**

The stated mission of the SCPAMHC is to foster collaborations that will improve public mental health services in South Carolina by:

- I. Preparing graduates who possess the knowledge, skills, and attitudes needed to be effective mental health workers in South Carolina's public mental health system.
- II. Developing a work experience in South Carolina's public mental health system both in rural and urban areas that is valued by employees as challenging and satisfying.
- III. Promoting research by faculty and graduate students that is utilized to improve public mental health services in South Carolina and nationally.
- IV. Providing educational experiences needed by current workers for continued effectiveness in South Carolina's evolving public mental health system.

During regular meetings of the Consortium and its subcommittees the members discuss relevant issues, seek solutions to problems, and then engage in efforts to bring about needed changes in the respective organizations. Committees conduct ongoing activities such as research on important issues, conference planning and implementation, and strategic planning and evaluation. Regular evaluation of the Consortium's work has demonstrated that its goals are being achieved effectively. In fact, because of its outstanding success, the SCPAMHC received the 1995 Award for Exemplary Collaboration from the American Psychiatric Association. As a result of the activities of the Consortium, the member schools and departments are increasingly sensitive to the changing educational needs of public mental health professionals. Academicians also become aware of the opportunities that are available to help to improve both the effectiveness of services and the productivity and job satisfaction of those who are employed in the mental health system.

The College of Social Work at the University of South Carolina has played a major role in the consortium. This role can best be understood within the context of public mental health services in South Carolina, including rural services. This context will be described below, followed by a discussion of the College of Social Work's involvement with the SCPAMHC.

## **Public Sector Mental Health Services in South Carolina**

The South Carolina Department of Mental (SCDMH) provides public sector mental health services to over 80,000 clients in 17 described below, followed by a discussion of the College of Social Work's involvement with the SCPAMHC.

## **Public Sector Mental Health Services in South Carolina**

The South Carolina Department of Mental (SCDMH) provides public sector mental health services to over 80,000 clients in 17 community mental health centers and five psychiatric hospitals located throughout the state's 46 counties. The annual budget exceeds \$300 million and services are provided by over 6,000 employees within a variety of inpatient and outpatient programs for adults and children ranging from emergency and screening services to community support services. The South Carolina Department of Alcohol and Other Drug Services (DAODAS) provides inpatient and outpatient treatment for alcohol and other drug abuse problems through 35 private/non-profit public agencies located across the state.

The recruitment and retention of clinically trained mental

civilians compared to the national rate of 11.3; there are only 19.5 master's and doctoral level social workers per 100,000 while the U.S. rate is 35.9 (Center for Mental Health Services, 1996). This rate differential is particularly disturbing given the fact that nationally social workers provide more direct client care services than the combined totals of psychiatrists, psychologists, and psychiatric nurses. Only 24% of the State's mental health counselors are social workers, and the paucity of mental health social workers is even greater in rural areas. One center which serves a rural population reports that out, for example, of 95 mental health providers, 13 (14%) are master's level social workers. This personnel shortage in rural areas is also a problem at the national level.

## **Availability of Rural Mental Health Services Nationally**

Almost one-fourth of the U.S. population resides in rural areas. The Center for Mental Health Services (1996) reported that between 1983 and 1990 the percentage of rural counties having some mental health services declined from 54.9 to 52% while the availability of services in urban counties increased from 95.1 to 95.7%. Although outpatient services are offered in many rural areas, overnight and inpatient services are generally not available. In areas where outpatient programs do exist, transportation to services can be an ongoing problem for clients and their families.

Recruiting and retaining professional staff to work in rural areas is a significant problem. Positions may remain open for extended periods of time or require the use of paraprofessionals to provide services. Also, in rural settings mental health professionals may be the only providers in their area, which often leads to their being disconnected from their professional disciplines and to having feelings of isolation. Mental health services, including those administered by managed care organizations, have become concentrated in urban areas which offer a broad range of inpatient and outpatient options

## **Impact of Managed Care**

The Institute of Medicine (1997) reports that at the end of 1995 over 60% of the U.S. population was covered by some form of a managed care plan. Behavioral health care benefits (a managed care term for mental health and substance abuse services) for 142 million people are administered through managed care plans. While the benefits and limits of these plans vary greatly, most offer a breadth of inpatient and outpatient services. On the other hand, over six million rural residents have access to a managed care plan. Behavioral health care benefits (a managed care term for mental health and substance abuse services) for 142 million people are administered through managed care plans. While the benefits and limits of these plans vary greatly, most offer a breadth of inpatient and outpatient services. On the other hand, over six million rural residents have access to only outpatient services (Center for Mental Health Services, 1996) which are often limited to daytime hours on weekdays. If evening, weekend, overnight, or emergency services are needed, rural residents often must travel to obtain the needed services. The Center for Mental Health Services (1996) notes that the time required for such travel may lead to an increase in the length of stay when inpatient care is needed. If transportation is not available, these services may be inaccessible to those in need. Hence, as managed behavioral health care plans expand into rural areas, there exists both the opportunity to improve rural mental health services as well as the risk that the current levels of care could remain stagnant or even decline.

**The Committee on Quality Assurance and Accreditation** Guidelines for Managed Behavioral Health Care recently identified several rural health care problems including "low numbers of physicians, financially fragile hospitals, low incomes, and low population densities" (Institute of Medicine, 1997, p. 162). The report states that "managed care plans in rural areas provide communities with opportunities to reduce health care costs, enhance the financial viability of practitioners, and overcome distances and isolation that can reduce the quality of health care in these areas" (p. 163). The report further states that rural problems, including a scarcity of mental health professionals, "do not generally restrict the usefulness of managed care, but managed care can provide opportunities and alternatives to overcome these problems" (p. 163).

However, behavioral health care has the potential to negatively impact rural mental health services. One significant problem in rural areas is managed care's "system for the credentialing of professionals as providers" which is a "quality assurance mechanism in which training, licensing, and quality of care are validated so that qualified clinicians are invited into the network" (Lourie, Howe, & Roebuck, 1996, p. 39). Managed care's mandate for licensed practitioners is a particular problem for the public sector mental health system. In South Carolina, two-thirds of the mental health counselors in the state are not licensed. In one rural mental health center, for example, only 4% of the direct service providers have licenses that permit reimbursement from managed care organizations. Clearly the need exists in South Carolina for more credentialed mental health providers, including social workers, in rural areas.

### **USC College of Social Work and Rural Mental Health**

Through the SCPAMHC, the College of Social Work at the University of South Carolina has expanded its potential to address rural mental health needs. The College of Social Work is the only graduate level social work program in the state offering both MSW and PhD programs and awards a total of 180-200 graduate degrees annually. The College has been an active member of the SCPAMHC since its inception and the Dean presently serves as Chair of the Consortium. Through its participation in the Consortium the College has realized benefits in four areas: faculty development; curriculum enhancement; expansion of student field placements and assistantships; and the provision of research, consultation, and continuing education in the public mental health sector.

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### **Faculty Development**

Since 1990, a number of the College's faculty have served on the Consortium's various committees. There has been significant benefit derived from the opportunity for faculty to interface with a wide range of other faculty and mental health representatives during the various meetings and committee activities available through the consortium. A quantitative study of the levels of collaboration within the consortium was conducted in 1996 (South Carolina Department of Mental Health, 1997). The study investigated four levels of collaboration and found that networking, or the exchange of information, was the most common method of collaborating in the organization.

technical and funding resources. The feedback obtained from faculty's involvement has led to an awareness in the knowledge base of individual faculty in the area of mental health, an awareness of mental health curriculum needs which the College should address, and the expansion of faculty involvement in mental health research and consultation.

### **Curriculum Enhancement**

Curriculum change at the College of Social Work is an arduous and slow process for several reasons. First, the bureaucratic nature of higher education and the importance of such principles as academic freedom and faculty governance make curriculum change a protracted process. Second, the Council on Social Work Education, which accredits social work programs, requires certain content and any changes, e.g. periodic curriculum policy mandates, are slow in coming from the organization. Third, individual social work faculty possess expertise, beliefs, and values that must be taken into account in curriculum development, and the melding of these interests usually takes time. Finally, as the state's only graduate social work program, the College must offer a broad range of content in order to prepare students for practice not only in mental health but also in other practice areas such as child welfare, economic services, health care, and gerontology,

Despite the impediments to curriculum change, the College has made progress towards expanding and improving the mental health content within the curriculum. Since joining the consortium, the College has placed an increased emphasis on hiring new faculty with expertise in mental health; over half of the new faculty hired in the last four years have practice backgrounds in mental health and offer significant teaching and research interests in this area. Progress is evident in the inclusion of mental health content in the curriculum. An elective course focusing on the DSM-IV is offered twice yearly and is selected by over 70% of the students. A recent elective on behavioral managed health care was chosen by 35 students from four different graduate programs. The large number of students enrolled in these two courses, including many from rural areas, is an indicator of the level of interest in mental health.

The College of Social Work has also developed a special program for delivering its MSW curriculum to students in rural areas through distance education. It was the first school of social work to teach courses through interactive television, having begun this program in 1980. Through this modality, the College offers all foundation courses (except practice methods) to students in 17 locations, including community colleges and USC regional campus locations, which are available throughout the state. Students commute to the central campus in Columbia on alternating Saturdays to take the foundation methods courses. Advanced courses are offered in Columbia in a format that requires the students' presence on campus only one or two days per week with field practicum placements arranged in the home communities of the students. This program has made it possible for numerous non-traditional students from rural areas (including

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advanced courses and various electives via interactive television. These will likely include courses with content concerning mental health such as psychopathology, pharmacology, case management, and managed care. This content will benefit not only MSW students, but also practitioners who seek continuing education opportunities.

Given the interdisciplinary interest in social work courses at the University of South Carolina, consideration is being given to rural curriculum recommendations outlined by the American Psychological Association (1995). Their rural mental health curriculum model suggests an interdisciplinary training approach using representatives from social work, psychology, and nursing. These disciplines are described as a "natural alliance" which is "especially needed in rural areas where existing resources must be maximized in order to provide mental health services" (p. 13). Focused training, internships, and continuing education are also consistent with licensure and managed care mandates.

Special training opportunities have been developed for students who are interested in careers in mental health. For example, "Step Into My Shows" is an inpatient psychiatric hospital experience offered to students through the SCPAMHC. Fifty-five graduate students from four different graduate programs have completed the program which includes spending two days and nights on an open inpatient state psychiatric ward to assume the role of a client.

#### **Student Field Placements and Assistantships**

In cooperation with the South Carolina Department of Mental Health, two mental health field internship programs are presently in place. First, the USC Institute for Families in Society and the College of Social Work implemented a project to provide focused training in school-based mental health services for students from four disciplines including social work, medicine, psychology, and counseling education. Since this program began in 1995, 28 social work students have received funding to participate in this project. Plans are now being made to fund 21 social work students in this program for the 1997-98 academic year.

Second, the USC Center for Child and Family Studies, the College of Social Work, and the South Carolina Department of Mental Health developed a collaborative project to provide specialized training in social work practice for MSW students who are interested in public sector mental health (Reid, 1997). In fall semester, 1996, eleven students began their MSW programs

Second, the USC Center for Child and Family Studies, the College of Social Work, and the South Carolina Department of Mental Health developed a collaborative project to provide specialized training in social work practice for MSW students who are interested in public sector mental health (Reid, 1997). In fall semester, 1996, eleven students began their MSW programs in the collaborative. While these are positive developments, the need persists for social workers in the state's mental health system, especially in rural areas. One barrier to be addressed is the lack of an organized social work department within the South Carolina Department of Mental Health which inhibits the nurturing of the discipline in this important state department. As managed care expands, it will be essential to increase the numbers of social workers and to ensure that they are well-prepared for their roles. The SCPAMHC should be helpful in facilitating the accomplishment of these goals through influencing organizational changes within the Department of Mental Health as well as in higher education programs.

#### **Research, Consultation, and Continuing Education**

The College has made significant efforts to assist rural mental health practitioners and administrators within training, research, and consultation support. Several faculty have conducted inservice training at rural mental health locations on diagnostic classification, personality disorders, and the use of reliable and valid assessment instruments. Also, the College conducts an ongoing series of 4-hour continuing education sessions which are held on Saturdays at a cost of \$30.00 each. These workshops have covered a wide range of topics including brief therapy, substance abuse, play therapy, assessment and evaluation, crisis intervention, managed care, ethics, blended families, spirituality, and others. The series provides an excellent opportunity for rural workers to obtain continuing education at an affordable cost, during a convenient time, and in a centrally located city within the state. Faculty also serve as consultants to rural mental health centers and have assisted with obtaining and analyzing data for accreditation requirements and assessing the outcomes of staff training and development efforts.

#### **Conclusion**

The problems, lack of resources and ongoing struggles faced by rural areas in providing and obtaining mental health services are well established. As difficult as matters may be in urban areas, the barriers that exist in rural areas often seem insurmountable. The South Carolina Public Academic Mental Health Consortium has provided a common ground to address some of the problems faced by the state's rural residents and to make some modest progress towards improvement. Although there is much more to be accomplished, the College of Social Work and the South Carolina Department of Mental Health have benefitted mutually from the relationships that have been established and sustained through the Consortium. Given the positive benefits experienced in South Carolina, other states are encouraged to develop consortiums and to share their efforts directed towards the improvement of rural mental health services.

#### **References**

- American Psychological Association. (1995). *Caring for the rural community: An interdisciplinary curriculum*. Washington, DC: Author.
- Center for Mental Health Statistics. (1996). *Mental health, United States, 1996* (DHHS Publication No. SMA 96-3098). Washington, DC: U.S. Government Printing Office.
- Institute of Medicine. (1997). *Managing managed care*. Washington, DC: Author.
- Center for Mental Health Statistics. (1996). *Mental health, United States, 1996* (DHHS Publication No. SMA 96-3098). Washington, DC: U.S. Government Printing Office.
- Institute of Medicine. (1997). *Managing managed care*. Washington, DC: Author.
- Lourie, I. S., Howe, S.W., & Roebuck, L.L. (1996). Lessons learned from two behavioral managed care approaches with special implications for children, adolescents, and their families. In *Mental health, United States, 1996*. (pp 27-44). DHHS Publication No. SMA 96-3098. Washington, DC: U.S. Government Printing Office.
- Reid, G. (1997). *The collaborative mental health project final report*. The Center for Child and Family Studies. Columbia, SC: Author.
- South Carolina Department of Mental Health (1997)

# Rural Consumers as Policy Partners: Do Service Providers Have a Problem?

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## Abstract

Mental health consumers are joining service providers on community boards and committees. While this may pose no problem for agency administrators, direct care providers have legal and ethical concerns about dual relationships with their clients. In a study of a rural mental health council, meeting records and a member survey were used to examine how service providers were reacting to these new forms of decision making parity with their clients. Findings showed the council relied on service providers to recruit consumer members and transport clients to meetings. Consumers had consistently lower attendance rates than service providers. Implications for rural mental health professionals, educators, and advocates are discussed.

## Overview

Health care reform and managed care have forced state policy makers to include mental health consumers on boards or councils designed to help states plan the allocation of mental health resources (Cuffel, Snowden, Masland, & Piccagli, 1996). In rural areas where specialists are scarce, services are widely dispersed, and poverty limits access to private care (Blank Eisenberg, Hargrove, & Fox, 1996; Sullivan, Jackson, & Spritzer, 1996; Wagenfeld., Murray, Mohatt, & DeBruyn, 1994), the consumer's voice may be essential to protect vulnerable public service recipients who have nowhere else to turn (Johnson, 1996).

A major impediment to active participation of mental health consumers on policy making boards and committees is the resistance of service providers to developing dual relationships with their clients. Dual relationships are those occurring "concurrently or in serial fashion" (Lowenberg & Dolgoff, 1996, p. 134) between a client and a service provider. For mental health administrators no longer engaged in direct practice, this may not be viewed as a problem. When direct practice service providers, however, sit on committees with their clients, they must also treat them as colleagues. For service providers engaged in such dual relationships, the disparity between professional roles becomes evident. In the role of direct practitioner, the relationship responsibilities for the service provider include protecting client confidentiality and client safety, providing a correct diagnosis and treatment, and avoiding dual relationships with clients. In the role of committee colleague, the relationship responsibilities for the service provider include treating clients as equal partners and consciously sharing power. Consequently, service providers are faced with two seri-

First, numerous authors have warned service providers about the ethical and legal problems inherent in maintaining dual relationships with clients (Abbot, 1995; Jayaratne, Croxton, & Mattison, 1997; Kagle & Giebelhausen, 1994; Kurzman, 1995; Loewenberg & Dolgoff, 1996). In addition, the social work code of ethics advises social workers not to engage in dual relationships which might harm or exploit clients (NASW, 1996). Kagle and Giebelhausen (1994) reported that the power and status inherent in the therapist or caseworker role will transfer to the board colleague relationship, preventing the formation of an egalitarian relationship between client and service provider. "The practitioner's power remains but is not checked by the rules of professional conduct or, in some cases, even acknowledged" (p. 217). The authors concluded, "practitioners found to have engaged in any dual relationships should have their licenses or certifications revoked" (p. 218). This raises serious concerns for service providers regarding participation on boards and committees when their clients are present.

Second, even if service providers were to view boards and committees as neither harmful nor exploitive, the concept, "dual relationship," is broad and ambiguous, and specific guidelines for professional behavior are lacking. While most service providers understand that ethical and legal sanctions against dual relationships mean no sexual contact (Borys & Pope, 1989), they are not sure how the concept applies when serving with consumers on community boards. A Michigan study of NASW members found that "although 22.6 percent reported serving on community boards or committees with clients, 41.3 percent questioned the appropriateness of this behavior" (Jayaratne, Croxton, & Mattison, 1997, p. 191). If mental health service providers are to take an active role in their communities and encourage their clients to do the same, then dual relationships are inevitable, particularly in rural areas (Jennings, 1992). Although service providers need specific guidelines for negotiating dual relationship, none exist. In spite of the absence of guidelines, states are asking service providers to engage clients as both consumers and colleagues. In Illinois, the Director of the Office of Mental Health asked regional public mental health administrators to establish advisory councils to provide a vehicle for consumer participation in mental health policy making. Prior research has described obstacles to consumer participation on policy making bodies (Elliot, Cohen, & Evans, 1995; Valentine & Capponi, 1989), yet no studies tell us how service providers and consumers are reacting to these new forms of decision-making parity. No studies describe the implementation of consumer-provider partnerships in rural areas.

## Method

A follow-up evaluation of a rural mental health advisory council was conducted after the council's first year of operation. The study examined attendance records and surveyed participants regarding their perceptions of the council's performance. Two questions guided the study. Will a rural mental health advisory council achieve and maintain membership parity between consumers and service providers? Will consumers and service providers have different perceptions of council performance?

## Study Site and Participants

The study was conducted in a 28 county rural region of Illinois. The area includes approximately one fourth of the state's land area, but only five percent (600,000 people) of the population. The region's towns and farms cover an area 115 miles wide and 150 miles long.

At the time of the study, the advisory council had been operational for one year. Service providers included staff from a state hospital, 16 community mental health centers, and three general hospital psychiatric units. Consumers included five members of two National Alliance for the Mentally III affiliates, two representatives from two GROW chapters, and the remainder were clients recruited from service providers' caseloads. The investigator served as co-chair during the council's first year.

## Procedure

The study used data from two sources. First, advisory council meeting records were examined to compare attendance patterns of consumers and service providers. Second, a member survey, especially designed for the study, was completed at the end of the council's first year. Questions dealt with members' perceptions of council goal attainment, overall council performance, and suggestions for improvement. Surveys were anonymous, but respondents were asked to identify their membership status as consumers or service providers.

## Results

Thirty members completed the survey, a response rate of 64 percent. The consumer response rate was 60 percent (12 consumers), and the service provider response rate was 67 percent (18 providers).

For the first study question, "will a rural mental health advisory council achieve and maintain membership parity between consumers), and the service provider response rate was 67 percent (18 providers).

For the first study question, "will a rural mental health advisory council achieve and maintain membership parity between consumers and service providers," membership recruitment did not achieve parity. The advisory council included 47 members: 20 consumers (43%) and 27 service providers (57%). Attendance rates for consumers also fell below attendance rates for service providers. During the council's first year, 19 percent to 35 percent of those present at meetings were consumers, compared to 66 percent to 81 percent of those present at meetings were service providers. Service providers were often over-represented at meetings because providers brought additional agency staff to participate in council meetings.

For the second study question, "will consumers and service providers have different perceptions of council performance,"

attainment. The mean overall council performance approval rating for consumers was 3.82 (s.d.=1.08) on a five point Likert scale, compared to a mean service provider rating of 3.24 (s.d=.75). Differences between consumer and service provider responses were significant ( $p=.012$ , two-tailed t-test) in only one case. Service providers, on average, gave a lower rating (mean=2.12) to the council's attainment of the goal, "setting standards to evaluate regional service delivery," compared to ratings of consumers (mean=3.08). In general, consumers and service providers reported similar strengths, namely the meetings were an opportunity for formal and informal information exchange among the constituencies. Consumers (42%) and service providers (71%) reported mental health jargon impeded effective communication. One consumer wrote, "I don't know what all the acronyms stand for. I get lost about halfway through the meeting." Service providers (29%) and consumers (17%) stated the council had no real authority to change services. One provider wrote, "It needs to be an elected board lobbying, advocating, and taking action on service needs for the area."

## Discussion

Not all service providers in the study shared the goal of membership parity between consumers and service providers. Lack of organized consumer groups (only four in the region) forced the council to rely on service providers to recruit and transport consumer members from their client caseloads. Clinicians were reluctant to transport "clients" in their cars. They raised ethical and legal concerns about how to manage egalitarian relationships with clients. Service provider resistance to relationships of equality with their clients may pose the most difficult barrier to making consumers full partners in policy making. The complexities of this issue must not be overlooked. Mental health professionals are taught to maintain clear boundaries between themselves and their clients. Such boundaries were designed to protect vulnerable clients from exploitation by mental health service providers. Client-service provider boards and committees transform clients into colleagues and challenge standard professional practices. Rural service providers are acutely aware of the need to protect client confidentiality, including exercising caution when acknowledging client relationships in public places. Traveling together with clients to meetings, talking about agency programs over lunch, or engaging in committee discussions about the quality of services, may be viewed as ethical or legal violations. Such exchanges, however, are essential to achieving a consumers-service provider dialogue.

Rural mental health service providers lacked guidelines to help them negotiate egalitarian interactions with consumer council members. In an increasingly litigious practice climate (Kurzman, 1995), it is not surprising to find service providers who are reluctant to recruit and transport clients to council meetings. Professional organizations, such as the National Association of Social Workers, must set standards of conduct to help practitioners cope with dual client relationships which are part of rural practice. Educators in schools of social work and psychology need to train professionals who can create consumer partnerships without compromising professional integrity.

Consumers and service providers in the study had not yet established a common language to facilitate a dialogue as equal partners. One solution attempted was to give consumers lengthy lists of acronyms and definitions. This remedy, however, failed to address the need to develop language relevant to the persons for whom services were designed. Both constituencies must set aside time in their crowded schedules to develop a compromise vocabulary which serves the needs of service providers and consumers.

Although membership parity was not achieved, the rural council in the study initiated a mental health policy dialogue between rural consumers and service providers. Representatives of both constituencies wanted a more substantive role in shaping rural mental health policies. In other states, such as Georgia, regional boards, "comprised of at least 50 percent consumers and family members" (Elliott, Cohen, & Evens, 1995, p. 418) are "responsible for planning, assessment, service coordination, contracting, needs assessment, resource allocation, and outcome evaluation" (p. 416). This study shows not all states have followed Georgia's example. In states where consumer boards and committees lack authority, consumer and service provider partners will need to use their combined political power to transform "advising" into more substantive decision-making roles. In such cases, addressing the ethical dilemma posed by dual relationships is even more critical. In addition, the rural areas in the study lacked organized consumer groups such as GROW, the National Depressive/Manic Depressive Association, and the National Alliance for the Mentally Ill. These groups help prepare consumers for an active role in policy making. Rural service providers need to promote and support the formation of more consumer organizations.

A carefully crafted mental health consumer-provider partnership may be the lynchpin advocates need to secure relevant mental health services for rural citizens. More studies are needed to examine how best to forge alliances between rural mental health consumers and service providers. Organizations, such as the National Association for Rural Mental Health, can help by disseminating educational materials about rural collaboratives, and providing a forum for model states to share their successes and failures .

## REFERENCES

Abbot, A.A. (1995). Professional conduct. In L.Beebe (Ed.) . . . and providing a forum for model states to share their successes and failures .

## REFERENCES

Abbot, A.A. (1995). Professional conduct. In L.Beebe (Ed.) Encyclopedia of Social Work, 19th edition, pp. 1916-1921. Washington, DC: NASW Press.

Blank, M.B., Eisenberg, M.M., Hargrove, D.S., Fox J.C. (1996). Introduction to special issue health care reform and rural special populations. Community Mental Health Journal, 32(5), 427-429.

Borys, D., and Pope, K. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. Professional Psychology: Research and Practice, 20(6), 282-292.

Cuffel, B.J., Snowden, L., Masland, M., & Piccagli, G. (1996). Managed care in the public mental health system. Community Mental Health Journal, 32(2), 109-124.

Elliott, R.L., Cohen, M.D., & Evans, D.L. (1995). Reforming Georgia's mental health system. Community Mental Health Journal, 31 (5), 413 -423.

Jayarathne, S., Croxton, T., and Mattison, D. (1997). Social work professional standards: An exploratory study. Social Work, 42(2), 187-199.

Jennings, F. (1992). Ethics in rural practice. Psychotherapy in Private Practice, 10, 85-104.

Johnson, J.R. (1996, Winter). Critical missing ingredients: The expertise and valued roles of people with psychiatric disabilities. Dialogue on Outcomes for Mental and Addictive Disorders. (Available from The Outcomes Roundtable, 200 North Glebe Road, Suite 1015, Arlington, VA 22203-3754).

Kagle, J.D., and Giebelhausen, P.N. (1994). Dual relationships and professional boundaries. Social Work, 39(2), 213-220.

Kurzman, P.A. (1995). Professional liability and malpractice. In L.Beebe (Ed.) Encyclopedia of Social Work, 19th edition, pp. 1921-1927. Washington, DC: NASW

Loewenberg, F.M., and Dolgoff, R. (1996). Press.Ethical decisions for social work practice, 5th edition. Itasca, IL: F.E. Peacock Publishers. National Association of Social Workers. (1996). NASW code of ethics. Washington, DC: Author.

Sullivan, G., Jackson, C.A., & Spritzer, K.L. (1996). Characteristics and service use of seriously mentally ill persons living in rural areas. Psychiatric Services, 47(1), 57-61.

Valentine, M.B., and Capponi, P. (1989). Mental health consumer participation on boards and committees: Barriers and strategies. Canada's Mental Health, 37(2), 8-12.

Wagenfeld, M.O., Murray, J.D., Mohatt, D.F., & DeBruyn, J.C. (1994). Mental health and rural America: 1980-1993. (NIH Publication No. 94-3500) . Rockville, MD: Office of Rural Health Policy. strategies. Canada's Mental Health, 37(2), 8-12.

Wagenfeld, M.O., Murray, J.D., Mohatt, D.F., & DeBruyn, J.C. (1994). Mental health and rural America: 1980-1993. (NIH Publication No. 94-3500) . Rockville, MD: Office of Rural Health Policy.

# Rural Telepsychiatry

by Cathy Britain

Program Manager of RODEO NET, La Grande, OR

*This paper is a summary of the information presented by a panel of experts at the National Association for Rural Mental Health Conference workshop on Rural Telepsychiatry sponsored by the federal Office of Rural Health Policy. It is intended to provide technical assistance using information and "lessons learned" offered by the panel. The panel consisted of Amy Barkin, from the federal Office of Rural Health Policy; Catherine Britain, program manager of RODEO NET, a telemental health program established in 1991, located in La Grande, OR; Dr. David Carlson, a psychiatrist/clinician from Eastern Montana Telemedicine Network, a telemedicine network established in 1992, located in Billings, MT; and Michael Jares, evaluation director of Eastern Montana Telemedicine Network, a telemental health program established in 1994, located in Helena, MT.*

## A History of Telepsychiatry

Telepsychiatry or telemental health, as some prefer to call it, has been practiced for over thirty years. Its history dates back to the very beginnings of telemedicine itself. One of the very first telemedicine projects and the first telepsychiatry project was in the early 1950's in Nebraska. Dr. Cecil Wittson, at the Nebraska Psychiatric Institute (NPI), at University of Nebraska Medical Center was able to view and broadcast to an entire classroom the activities taking place in an interview room. These live, one-way demonstrations were broadcast via cable conduits using a television system with a camera installed behind a one-way mirror.

Nebraska Medical Center continued to be the leader in telemental health applications:

- In 1956, the National Institute for Mental Health (NIMH) funded an interactive communication link between seven state hospitals in Nebraska, Iowa, North Dakota and South Dakota. The system was essentially a glorified conference call, with microphones and speakers at each site and included a primitive visual transmission. It was used to broadcast the Nebraska Psychiatric Institute's weekly visiting lecturer series.
- In 1959, again funded by NIMH, Nebraska Medical Center developed a system which allowed interactive audiovisual call, with microphones and speakers at each site and included a primitive visual transmission. It was used to broadcast the Nebraska Psychiatric Institute's weekly visiting lecturer series.
- In 1959, again funded by NIMH, Nebraska Medical Center developed a system which allowed interactive audiovisual contact throughout the campus and was used for demonstration and teaching purposes.
- In 1961, the NPI performed the first telepsychiatric consultations, in which a psychiatrist was able to see patients for group therapy over closed circuit television connections. Based on the success of these demonstrations, Nebraska Medical Center received a six year grant from NIMH to open an interactive audiovisual link with Norfolk State Hospital, using microwave technology to traverse the distance.
- In January, 1965, a psychiatrist in Omaha began to spend about 30 minutes a day using the microwave technology to contact both patients and personnel of a 35 bed ward in

- In 1970 some of the Veteran's Hospitals in Nebraska - Omaha, Lincoln and Grand Island - joined the network of users.

Other sites which developed significant telemental health applications during this period were:

- Massachusetts General Hospital - in 1968, Thomas Dwyer, M.D. developed a telepsychiatry project in Boston between Massachusetts General Hospital and Logan Airport Air Station Clinic. The results of the project were determined to be positive from a clinical standpoint.
- Dartmouth Medical School - In 1970, closed circuit interviews were begun between Dartmouth Medical School psychiatrists and patients with their community physicians present.
- Mt. Sinai Medical School - in 1976 child psychiatry evaluations were conducted between Mt. Sinai Medical School and Harlem Clinic in New York via a cable TV linkage.

During the first period of development for telemedicine (1955-1980), psychiatry or mental health was considered to be one of the most robust applications for telemedicine. In the 1980's telemedicine nearly ceased to exist. The grant and development money offered by the federal agencies was no longer forthcoming, technology and carrier costs were extremely high, and no thought had been given to long term sustainability. Most programs disappeared.

In the early 1990's there was a resurgence in interest in telemedicine. Health care costs were rising rapidly. Access to quality services was becoming more limited in rural and inner city areas. Federal agencies were again interested in funding programs which could demonstrate that telemedicine might increase access to quality care and at the same time reduce costs. The cost of the technology had dropped significantly and quality had improved dramatically. Some carriers were offering services on a more cost-effective basis, and those that weren't came under heavy pressure to do so often from state governments.

Surprisingly though, as interest in telemedicine grew in the early 90's interest in telepsychiatry or telemental health did not. In 1995 there were only six telemedicine programs in the weren't came under heavy pressure to do so often from state governments.

Surprisingly though, as interest in telemedicine grew in the early 90's interest in telepsychiatry or telemental health did not. In 1995 there were only six telemedicine programs in the United States with exclusive or significant telemental health applications. The opinions and advice offered in this paper are from representatives of three of those programs.

In 1996, interest in telemental health applications began to grow at a rapid rate, and today 25 programs report exclusive or significant telemental health applications. In applications for federal funding for telemedicine programs, telemental health is listed as one of the primary applications to be developed. The American Psychiatric Association and the American Psychological Association are both in the process of developing standards for the delivery of mental health services via telecom-

activity, telepsychiatry and telemental health will be among the leading applications setting the benchmarks for the development of telemedicine in the 21st century.

### The Federal Role

Federal agencies have a history of involvement with telemedicine since the mid-50's. The National Aeronautics and Space Administration, the National Institute for Mental Health, the Department of Health and Human Services and the Rural Utilities Services program all had early roles in funding and supporting telemedicine projects.

The Office of Rural Health Policy (ORHP), founded in December 1987, has funded outreach demonstration grant programs using telemedicine and telemedicine grant programs since 1988. To date, ORHP funding has enabled programs to begin using telemedicine.

Since 1995, the ORHP has chaired the Federal Joint Working Group on Telemedicine (JWGT). This group had its beginnings in 1992 when the Information Infrastructure Task Force, under the leadership of the Department of Commerce, began to examine broad innovative uses of the National Information Infrastructure (NII) and began to coordinate initiatives throughout the federal government. In 1994, the Department created the Health Information Application Working Group with a subgroup that focused on telemedicine. In 1995 Vice-President Gore identified telemedicine as a key area for development in the National Information Infrastructure. He asked that the Department of Health and Human Services take a greater leadership role in developing cost-effective health applications for the NII. At this point the Department of Commerce joined forces with the Department of Health and Human Services to form the JWGT.

Currently, the JWGT is a government-wide entity with a focus on telemedicine that has grown to more than 9 federal agencies and over 80 individual representatives from federal agencies and professional associations involved in telemedicine technologies. The JWGT is charged with assessing the role of the federal government in telemedicine and coordinating activities across federal cabinet agencies. Part of the task involves developing specific actions to overcome barriers to the effective use of telemedicine technologies - barriers such as reimbursement, licensure, and access which will be discussed in this paper.

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Current uses of telepsychiatry/telemental health in rural areas  
All of the programs report using video conferencing, currently the most common venue for delivery of services, to provide the following:

1. Psychiatric consultation
2. Evaluation
3. Medication management
4. Treatment and discharge planning
5. Legal hearings

In addition Dr. Carlson reports that Eastern Montana Telemedicine Network (EMTND) uses the network for peer

Southwest Montana Telepsychiatry Network (SWMTN) also uses the system for peer and family visits for both hospitalized consumers and those in the community.

There are other non-consumer based telemental health services that all the networks are used for such as meetings and education/training.

Ms. Britain reports that RODEO NET also considers the use of computer-mediated networking as a venue for the delivery of telemental health services. Services delivered via computer conferencing include provider governance, information management, consultation, education, meetings, and provider and consumer networking.

### Lessons learned

1. Reimbursement - All three panelists reported that State Medicaid programs in Montana and Oregon were paying for services as they would in a face-to-face visit through the state Medicaid managed care programs - Montana Community Health Partners and Greater Oregon Behavioral Health, Inc. This means that provider fees are paid for - in Oregon under the capitation rate and in Montana under fee for service. Additionally, RODEO NET has negotiated a contract with Greater Oregon Behavioral Health, Inc. to pay for transmission costs. Both SWMTN and EMTN are negotiating with Montana Community Health Partners for contracts to pay for transmission costs. Dr. Carlson states that should the negotiations prove unsuccessful that EMTN is prepared to present the transmission costs as a direct expense to patients, but stated that "the expenses of driving to Billings, time off from work, family members that might have to accompany, the possibility that they may have to stay overnight are all things that they may be able to avoid". Dr. Carlson also reports that EMTN has had success in negotiating contracts with other third party payors such as Blue Cross/Blue Shield.

All panelists agreed that impact of the recently passed federal legislation proposed by Senator Kent Conrad of North Dakota would be significant. This legislation requires Medicare to pay for telemedicine services provided to rural areas. It is still unclear, at this point, how HCFA will define rural areas.

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All panelists acknowledged that the technology is rapidly changing. The advent of ATM technology will allow more flexible use of bandwidth using a dial-up pricing strategy. Single platforms for voice, video and data will make the use of the technology from the desk top more viable.

2. Licensure - Licensure has not proven to be an issue for any of the panelist's programs, as none of them currently offer services out of state. All believe that in the current environment that, should they want to practice out of state, individual state licensure would be required.

Both Dr. Carlson and Mr. Jares felt that states should have the right to require full licensing in order to practice telemedicine

Ms. Britain believes that national licensing is a better, but not realistic solution. A more realistic solution might be universal reciprocity which requires the telemedicine practitioner to consult with the licensed provider in the state who is legally responsible for the patient's care. A similar law is currently in place in California.

All panelists stated that initial training for service providers was important both in use of the equipment and presentation skills. Periodic updates should be provided. The amount of training needed varied significantly from minimal expressed by Dr. Carlson to significant expressed by Mr. Jares.

3. Confidentiality - There were not a lot of concerns expressed with regard to confidentiality. The technical concerns are being quickly resolved and those that remain have to do with human factors. Mr. Jares noted that technician involvement in the consultation was a problem in SWMTN until a policy was changed to allowed technicians to leave the room during the conference. Ms. Britain noted that it was important that technicians all receive confidentiality training and sign confidentiality forms on a yearly basis.

A more difficult issue with regard to confidentiality has to do with being in a small community. Dr. Carlson expressed it this way, "Very frequently the professionals in the communities do not want to use telemedicine. They usually are going out of town to see the psychiatrist anyway for privacy issues; and if they go down to the local hospital or the local Mental Health Center during Dr. Carlson's telemedicine time, I think rightly so, they figure people know that there's some kind of problem there. So those are patients that more often than not, are not going to use telemedicine."

#### 4. Other learnings

Ms. Britain and Mr. Jares offered the following learnings with regard to implementation:

- a. "Build it and they will come." A telemedicine system must meet identified needs. Simply having it available does not guarantee that it will be used. It must also be acknowledged that needs will vary from one community to another and that a "cookie cutter" approach does not work.
- b. Expertise is needed to successfully deal with both carriers and vendors. Naivete comes with a high price tag. Learn from others or hire someone who has successfully worked with both vendors and carriers.
- c. Collaboration is a must. In order to be successful though partners must commit to their roles, and follow through. Trust and honesty must be established. Commitment to the partnership must occur before the project begins.
- d. Programs must be patient with the paradigm shift. Coping with managed care and new information management systems has most providers already reeling from change overload. Begin with a small group of interested providers, encourage evangelism and slowly build the system.
- e. Invest as heavily in human infrastructure as technological infrastructure. Training and supporting the people who use

take an active role in determining the way telemedicine is regulated both at a state and national level. And they must be attentive to the way telecommunications infrastructure is being deployed especially to the rural areas of their states. Failure to be involved can result in regulations or infrastructure deployment that can threaten the success of the program.

- g. The technology must be incorporated into the way a provider does business. It cannot be an add-on, a new toy, so to speak. The technology cannot add to an already heavy workload - rather it should help relieve it. The technology should replace traditional ways of doing business because it is more efficient, more effective and is cost beneficial.

Dr. Carlson offered some technical issues that are of specific concern to clinicians:

- a. Scheduling patients - "I found it is much easier to schedule patients in blocks...It is easier if they're in one community because I don't have to switch the system from site to site... we really don't have time to wait around for those things (switching) to take place. To that end, I also have to be sure that I am pretty much running on time. It is very difficult to go overtime with these patients which we can sometimes do in our offices by running into our lunch hour or a break time...it is fairly easy to reschedule patients in situations that otherwise would not be amenable to rescheduling (due to distance between patient and provider)."
- b. Rural site locations - These concerns included 1) the use of unsuited rooms which had lots of audio problems (echoes), and privacy issues ("interruptions that were not only embarrassing but intolerable in the psychiatric setting"); 2) trained technicians that could handle problems on site and coordinate with the technicians at the hub site; 3) the use of equipment intended for educational rather than consultation - room microphones instead of tabletop microphones, feedback monitors ("I have asked the technicians to turn off the feedback TVs...I usually feel less distracted if I turn it off for myself and have the patient turn off the feedback TV at their site.")

Dr. Carlson also offered his view of the clinical advantages and disadvantages of using technology to deliver services.

Advantages noted were:

- a. Reduced travel for the patient - "It is certainly a significant advantage for the patient to have their care delivered at their site."

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Advantages noted were:

- a. Reduced travel for the patient - "It is certainly a significant advantage for the elderly. In my practice in Billings in earlier years, it was not unusual that I'd have an older person who had decompensated medically because of the trip to Billings. The chronically mentally ill who have very few resources can make their appointments more reliably and more frequently if we desire that. The other advantage is that their case manager at the local mental health center is also able to accompany them to their visits which otherwise would be impossible financially or logistically...this is very helpful for us in evaluating the patient to find out the 'rest of the story', other concerns, as well as to educate the local

"We have found that this technology has really improved our relationship with the local referring doctors and clinicians. Being able to see them, make eye contact, is a very interesting phenomenon especially when you're used to the old way of taking care of dozens of patients for someone over a few years and never actually knowing what they look like or seeing their interactive style. We can do three-way interactions which are very useful with youth who are in a residence outside of their home community. Mom and dad can be included in those visits easily."

- c. Decreasing attention patients associate with illness - "Ending the interview is much easier, especially with those stickier, clingy patients. We can just say goodbye and, rather than waiting for them to get out of the office and go through the usual passive-aggressive maneuvers, we just turn them off. The technology also decreases some of the reward for those mentally retarded and hypochondriac patients who seem to really enjoy staying in the waiting room or enjoy the trip to Billings and begin to associate it with illness or sick behavior."
- d. The technical capability to "zoom" - Zooming the camera in on a particular patient behavior or movement without them being aware of it allows psychiatrists to get better information about the behavior or movement. Dr. Carlson feels the information is more accurate when client is not focused on the behavior or movement and subsequently trying to inhibit or exaggerate it.
- e. The marketing advantage - Psychiatrists in Billings are looking at telemedicine as an advantage when they market their PPO to insurance companies. Using telemedicine they feel that they can offer better services and employees will use less time off to take advantage of these services.
- f. The ability to use telemedicine sessions as a teaching tool - Sessions can be taped for later use, or students can observe live sessions seated off camera. This helps reduce the self-consciousness of patients with regard to having a third party present. It is an excellent tool for teaching such things as outpatient medication management.

#### Disadvantages noted were:

- a. Initial loss of connection and transference - Dr. Carlson believes that some of the initial "feel for the patient" is lost with telemedicine. He prefers not to see people initially over the system, but face to face. Although he has done initial sessions using the system, he feels "it's a little more difficult to figure out what we're dealing with". He also thinks
- a. Initial loss of connection and transference - Dr. Carlson believes that some of the initial "feel for the patient" is lost with telemedicine. He prefers not to see people initially over the system, but face to face. Although he has done initial sessions using the system, he feels "it's a little more difficult to figure out what we're dealing with". He also thinks that "there are some differences in the psychodynamics of prescribing medications to patients in terms of some of the transference and some of the placebo effects".
- b. Patients who don't do as well with telemedicine - Carlson states that "there are certain patients who don't seem to do as well with telemedicine. These patients are usually difficult patients in the office as well. They are highly defensive and guarded. These are the patients who might have a post traumatic stress disorder. Its also been a little harder for me to pick up on personality disorders when I haven't seen the patient in the office before." Carlson also believes

c. Difficulty using sample medications - It is difficult to use sample medications with telemedicine sessions. He prefers not to put them in the mail, yet without the samples it is more difficult to get Medicare patients to begin using the more expensive drugs.

#### 5. Structural design

- a. Changes in mental health service delivery brought about by the use of technology - All of the panel members indicated that there had certainly been changes brought about by the use of technology, but that these changes were not necessarily organization or region wide. Most of the changes that had occurred were in individual practices or in a specific service such as pre-discharge planning.

Mr. Jares noted that "Montana State Hospital has added outpatient clinics to their services as a result of a combination of the technology and the state delivering mental health services through a managed care company". He also added that an advanced practice registered nurse has found it more efficient to schedule a day or a half day to do clinics with the video rather than to see one patient per day on the system. He stated that most service providers see more people in one day over the system than can be seen on a face-to-face basis. However, practitioners had found that "a lot of the personal contact through "chit-chat" had been lost when providing service over the video system".

Ms. Britain noted that, in general providers had learned that it was easier to move information than people - be it staff or consumers, and that there was more time to spend on service delivery when the system was used. These lessons have not yet been totally incorporated into the way providers do business. This is a slow process, but managed care may help to speed it along.

Another change noted was that the delivery of services is more inclusive. The technology has encouraged the development of real team-based services by removing time and distance barriers that previously discouraged professionals from working cohesively with the consumer and his family.

- b. Data collected - All panelists reported that for the most part, the only consistent data collected was provider and consumer/family satisfaction data. Ms. Britain also reported that RODEO NET collects information about the outcome of the session. More data isn't collected because there is usually not money allocated in the budget for data collec-

- b. Data collected - All panelists reported that for the most part, the only consistent data collected was provider and consumer/family satisfaction data. Ms. Britain also reported that RODEO NET collects information about the outcome of the session. More data isn't collected because there is usually not money allocated in the budget for data collection and management. This is especially true for programs once grant funding is ended.

- c. Outcome measures - None of the panelists reported using specific outcome measures. Ms. Britain reported that RODEO NET has been discussing with Greater Oregon Behavioral Health, Inc. appropriate outcome measures for services delivered via the technology and whether or not these measures should differ from those for face-to-face sessions. In the future, it is likely that managed care organizations will specify the outcome measures for use of the technology and will provide the financial incentives needed

d. Sustainability - Ms. Britain summarized the sustainability issues for telemental health as:

- continued support of managed care. The support of behavioral health managed care companies will largely determine the continuation of telemental health services, especially in rural areas. It is, therefore, important to work with these companies to develop outcome measures and collect data which supports its use so that they continue to pay providers for using it and help to financially support the infrastructure.
- Single platforms that support voice, video and data applications over flexible, fractionalized bandwidth. It is important for providers to work with vendors of software and equipment, and with carriers to develop cost-efficient systems. These systems will only be developed if providers persist in making their needs known and advocating for them. It is also important that providers plan for an efficient transition to these systems in order to realize maximum cost benefit.
- Continued collaboration for technology deployment. Rural mental health programs cannot support telemental health networks. In many states initiatives are underway to support the development of rural infrastructure by encouraging organizations and state agencies to partner in the deployment of needed carrier services to their areas. These initiatives do not discourage the development of separate networks, rather they encourage networks to share bandwidth.
- Incorporation into the way we do business. As mentioned earlier, it is perhaps most essential that we cease to view the technology as an interesting project and incorporate it into the way we do business. In order for technology to be widely deployed, an organization must set the expectation from the top down that it will replace - not add to - the tasks that are done on a daily basis. This requires an organization to invest in training and support as heavily as it invests in hardware and software.

#### **Summary**

Although telemental health has a long history, only in the past year has there been robust growth in this telemedicine application. From the outset, federal agencies have played a significant role in the development of telemental health by providing funding for projects, and focusing government attention on

#### **Summary**

Although telemental health has a long history, only in the past year has there been robust growth in this telemedicine application. From the outset, federal agencies have played a significant role in the development of telemental health by providing funding for projects, and focusing government attention on developing specific actions to overcome barriers such as reimbursement, licensure and access to technology.

The three programs represented utilize the technology to provide many of the same kinds of services such as consultation, evaluation, medication management, treatment and discharge planning and legal hearings, and non-clinical uses such as meetings and education and training.

The three panelists also reported similar lessons learned with regard to reimbursement, licensure, and confidentiality. Other

Dr. Carlson offered insights on the advantages and disadvantages of using the technology from a clinical perspective. Among the advantages noted were reduced travel time, improved relationships with local doctors and clinicians, decreasing the attention patients associate with illness, the enhanced ability to focus on movements and behaviors, the marketing advantages, and the ability to use telemedicine as a teaching tool. Among the disadvantages noted were initial loss of connection and transference, patients who don't do well with telemedicine, and difficulty using sample medications.

With regard to structural design all panelists noted that changes were not wide spread, but tended instead to be individualized to a practitioner or group of practitioners, or to a specific service. All agreed that it was easier to move information than people and that most of what has been learned has not yet been incorporated in the way we do business.

All panelists agree that the data collected was primarily limited to provider and consumer satisfaction primarily due to the lack of program funds to collect and manage data. The same was felt to be true with regard to the development and implementation of outcome measures. Managed care organizations will likely drive this effort.

Sustainability issues for telemental health involve the ongoing support of managed care, single platforms that support multiple uses, continued collaboration for technology deployment, and incorporation of technology into the organization.

In conclusion, all panelists believed that the use of technology to deliver mental health services was a positive step in increasing access to services and improving the quality of care in a cost effective manner. The panel acknowledged that managed care organizations would be powerful drivers in the deployment of telemental health services and would play a significant role in overcoming the barriers. All agreed that telemental health will be one of the leading applications in the development of telemedicine for the 21st century.

*A special*

**"THANKS"**

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***Federal Office of Rural  
Health Policy***

***for 1997 conference support***

***of the Telemental Health Workshop***

# 1996 Victor I. Howery Award Acceptance Speech

by Dennis F. Mohatt

To say I am moved, to be nominated and selected as the 1996 recipient of the Victor I. Howery Award, would be a bit of an understatement. Where does one start? As with most good things in life, one must begin with thanks. I am grateful to many; my wife Karen, who has supported and nurtured my work through both her professional partnership and love; our daughter Kathryn who is my greatest joy; and to my brothers, Gerald and Richard, whose guidance and exemplary example of commitment to public service has always provided my touchstone.

Thank you, to the seventeen persons who have received the Howery Award before me. I have been very fortunate to have known and worked with most of these individuals, they have given me the gift of their mentorship, it is somewhat daunting to now realize I must join them and accept the heavy responsibility of being a mentor.

Finally, to Peter Keller and Denny Murray, both Howery Award recipients, my graduate school professors, my dear friends and peers. First, my appreciation for looking through my application for graduate study and seeing potential in the midst of that mess! Second, my gratitude for nurturing my education and my pursuit of a career focused upon rural psychological practice and advocacy for the equitable consideration of rural people and their needs in the development and implementation of health policy.

To me, service to the community and a career as a public servant means a great deal. Although some in our society seem to hold public service and public servants in contempt, usually as a means to promote a self-serving agenda, I believe public service and the commitment to others is the cornerstone of American society. I come to this conviction the hard way, as with so many of life's lessons. My father, a volunteer fireman in a small Iowa farming community, died in the line of duty when I was just fourteen months old. I was given by him a heritage of knowing that to serve our fellow citizens is important and the commitment to others is the cornerstone of American society. I come to this conviction the hard way, as with so many of life's lessons. My father, a volunteer fireman in a small Iowa farming community, died in the line of duty when I was just fourteen months old. I was given by him a heritage of knowing that to serve our fellow citizens is important work. Growing up in that small community I heard so many times people's appreciation for my father's sacrifice. Those messages gave me strength to weather the many storms life would throw my way.

My mother has suffered from schizophrenia her entire adult life. This illness resulted in, essentially, my being orphaned. For the past 30 years I have lived not only her disability, the fights for adequate care and human dignity, but of my own struggle to move beyond poverty. Few other illnesses are such a rapid ticket to poverty, nor hold such enduring financial and emotional family-wide consequences. As we look to what we

dry the very resources, financial and emotional, which are essential to support individual recovery.

Today I wish to speak to three simple issues that I believe are critical in moving behavioral healthcare for rural Americans forward. These issues are coverage parity with other health conditions in the insurance market, integration with the overall health care system, and stigma.

Today in the Congress of the United States the mental health parity amendment, offered by Senators Wellstone and New Mexico's own Deminichi has passed the Senate. Should this amendment be sustained in conference with the House, it would create the first step toward the abolition of systematic sanctioned discrimination of persons with mental illness. The end result of inadequate private insurance coverage for mental illness is a transfer of the responsibility for the cost of care to government. It baffles me that in an era of such strong, and vehement, opposition to high taxes and government involvement in health care, the private sector is not only allowed, but enabled, to shift this cost to the public sector. Would the public accept his responsibility for cancer, AIDS, or other classes of illness? I think not. As a matter of fact, if it was suggested in most state legislatures that new public institutions be constructed and staffed with taxpayer funds to care for persons with AIDS, the fallout would be enormous. The first step in preventing mental illness' financial devastation of families, is to ensure benefit parity. We can do better, and we must.

For years we have known that the primary care providers across the country constitute, according to Daryl Regier and others, a "defacto mental health system". Surveys consistently reveal that persons experiencing mental illness present first to their primary care physician and would prefer to receive their specialty mental health care in that setting. However, in rural America, the primary care system is stretched to meet these needs. Instead we have established systems of care and providers which operate parallel to each other at best, and often that persons experiencing mental illness present first to their primary care physician and would prefer to receive their specialty mental health care in that setting. However, in rural America, the primary care system is stretched to meet these needs. Instead we have established systems of care and providers which operate parallel to each other at best, and often are counter productive. The cost alone of dual systems for rural environments, where resources for both primary care and behavioral health services are chronically limited, is wasteful. However, it is the detriment to continuity of care which is of greatest concern. We must create new systems where a partnership of care exists between behavioral health and primary care. We can do better, and we must.

Finally let's chat about stigma. During the 1992 Presidential campaign a sign hung in the Clinton-Gore war room which read "it's the economy stupid". The message was simple, the economy was the root of the problem faced by most of the vot-

mom became acutely ill and required involuntary hospitalization, in 1967, I was 13 years old. When I came home from school my brothers told me what had happened I felt not only great fear, concern, and sorrow, but shame. At age 13 I already knew that to be put in a state institution was to go to the "funny farm", the "loony bin", the "nut house", etc., and in the midst of watching my life change so dramatically I faced the shame.

Stigma impacts the ability of persons with mental illness to recover, the way the health care system provides care, the appropriate of funds for care, and the basic human dignity of everyone touched by the illness. At 80 years of age, last summer, my mother who resides in a nursing home, was experiencing an acute exacerbation of her schizophrenia and needed her medications evaluated on an inpatient basis. I was in Washington, DC at a meeting set up by Tipper Gore to examine the impact of managed care, so wasn't available to be reached by the nursing home. When they finally reached me, I was informed my mother had been transported by the Sheriff's Department to the hospital 90 minutes away in Des Moines. You know, if she'd needed coronary care she would have been transported in an ambulance. We can do better, and we must.

Thank you again for this honor, and let's all work together to make things better.

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## **It's Time to Give a Tinker's Dam**

*by Paul Sundet, Ph.D., U of Missouri, School of Social Work, Columbia, MO*  
*Howery Award Luncheon*  
*August 8, 1997*

It is with both deep gratitude and a large helping of humility that we accept this most prestigious award. Our thanks go to the National Association for Rural Mental Health and its board of directors for considering us, particularly in light of the many professionals and lay-persons alike, some of whom are in this room today, who have made such signal contributions for furthering the cause of mental health in non-urban settings. We would like to also acknowledge the Howery family whose support makes this award possible while it does honor to a genuine pioneer in the field. Jansen Pharmaceutical Co. has long promoted the rural mental health movement and Joanne and I room today, who have made such signal contributions for furthering the cause of mental health in non-urban settings. We would like to also acknowledge the Howery family whose support makes this award possible while it does honor to a genuine pioneer in the field. Jansen Pharmaceutical Co. has long promoted the rural mental health movement and Joanne and I would specifically like to acknowledge their subsidy which has made our attendance at this conference possible. And while we have the opportunity we would also like to thank our gracious hosts, Mike Jacobsen and Dawn Botsford and their staffs, for their dedication in bringing this conference to reality in the face of what, for most of us, would have been insurmountable obstacles.

As I noted, it is a humbling experience to be honored by ones peers, particularly in light of our predecessors who have received the Howery Award - several of whom are present with us today. It brings to mind an incident that occurred on the

an unscheduled appearance. Finally, in the last five minutes of the program, the final guest, George Gobel, was introduced. He came out, sat down, looked down the couch at the others, turned to Carson and said, "Did you ever get the feeling that the whole world is a tuxedo and you're a pair of brown shoes?" Remembering who else have been Howery honorees gives us great appreciation for how Gobel felt that night.

Some of you may wonder why I am speaking on behalf of both Dr. Mermelstein and myself. She is, of course, an articulate and forceful speaker and, as her colleagues from the NARMH Remembering who else have been Howery honorees gives us great appreciation for how Gobel felt that night.

Some of you may wonder why I am speaking on behalf of both Dr. Mermelstein and myself. She is, of course, an articulate and forceful speaker and, as her colleagues from the NARMH board can attest, not reluctant to take and defend a position. It was her decision that I speak for the team and there are, I think, two reasons behind her choice: 1) she has been spending a great deal of time preparing for the workshop on natural disaster response to be held tomorrow afternoon. That session is bringing together experts from this and the other states that have recently been ravaged by the elements and she wanted me to share the workload; 2) but I suspect a second reason that dates back several years to Colorado State at a meeting of the National Institute on Social Work and Human Services in Rural Areas. We were seated in the auditorium awaiting the start of the first general session and two earnest young faculty members

ing to a litany of the saints, Hargrove (pray for us), Ginsberg (pray for us), Wagenfeld, Martinez-Brawley, Kessler, Jacobsen and so on. Eventually, the exchange began to slow down as each searched for a more obscure name. Finally we heard my name and, like Snoopy when he hears his supper dish bang, my ears stood up waiting to discover what they would say about me. And the first one said, "He's dead, isn't he?" To which the second responded, "Oh yes, he died a long time ago". It is my suspicion that my dear colleague asked me to speak on our behalf because she wanted to give this august group about fifteen minutes in which to confirm that diagnosis.

It is often difficult to find a way of organizing thoughts when called upon to address colleagues but a distinguished member of the United States Congress came to our rescue. In a recent interview on CNN he referred to persons in the broad field of social welfare as "TINKERS". At first I thought he was intending to make a pejorative statement and that what he really meant to say was "tinkerers" but on reflection I realized that this is not only an American Historian but a sometimes professor and therefore he could not possibly have made such an error. And since he must understand the role of the TINKER in our rural and frontier history, I would gratefully accept his compliment.

For there is nothing wrong with being a TINKER. In our history it has been an honorable profession. The TINKER went from rural hamlet to rural hamlet, selling essential housewares and mending essential pots and pans. And he (or she because there were a few women in the profession) also brought news of the outside world, of the latest innovations. The TINKER was a direct descendent of the medieval minstrel.

Certainly there are some essential instruments in our communities that today are broken and need mending. And the need to share information and spread innovation is greater than ever. So I am proud to be called a TINKER - and I'm honored to address a TINKER'S CONVENTION - for that is what all of you in this room are trained to be: the menders, the fixers, the instigators, the innovators.

Prominent in this conference program and that of the Rural Institute which starts on Sunday are two topics where the leaks and holes for rural clients and practitioners alike are most obvious. The first is managed care (or damaged care, depending on your point of view) and the other is welfare reform. Both are

Prominent in this conference program and that of the Rural Institute which starts on Sunday are two topics where the leaks and holes for rural clients and practitioners alike are most obvious. The first is managed care (or damaged care, depending on your point of view) and the other is welfare reform. Both are having enormous and often unintended impacts on rural life. We will defer to the experts that the program committees have brought together to address the intricacies of these extremely complex issues. However, we would point out here that with managed care, the topics such as confidentiality of records, capitation and definitions of "medical necessity" have unique repercussions on rural practice and practitioners. Welfare reform translates into welfare reduction in most of our communities and the standardized provisions for job training employment quotas, child care facilities - to say nothing of SSI eligibility redeterminations, etc. - were written with mass transit, neighborhood schools, extensive support systems and large employers

The commonality of these two critical emerging areas is that they both have four underlying problem components that must be addressed from a uniquely rural perspective. These include: 1) the availability - of financial and programmatic resources; 2) access - to appropriate care as needed; 3) linkage - coordination and non-duplication of service delivery systems; and 4) accommodation - to social, economic and technological change imposed from outside the environment.

Do those issues sound vaguely familiar to you old-timers and/or historians of the rural mental health movement? They should for thirty-five years ago those were also the salient issues. As one of Missouri's famous native philosophers, Yogi Berra, would say, "deja vu all over again." But long ago we were all trained that a crisis is an opportunity as well as a danger. For almost twenty years from the early '60s to the early '80s those same four troubling concerns gave rise to the greatest surge of creativity that this field has ever known. How we respond to these same concerns today is a function of our perception of the hazardous event and our own personalities.

### **Ethel story**

Yes it is easy to find the down side, to put a negative spin, to bemoan how once again rural issues and rural concerns have been left behind. But to what end? What good does the hand wringing do?

So, let us return to the TINKER for a moment. Besides repairing the broken, fixing the damaged, renewing the worn, the TINKER performed another highly valued task. In the wagon was a tiny lathe with a very fine grinding stone used for only one purpose. In frontier America a most highly prized commodity was a sharp needle - because everything had to be mended and patched and repatched. And a regular grinding wheel could snap, or make flat spots or blunt a needle. So when the TINKER came, those precious items were entrusted to him to refurbish. Is there a connection to this 23rd ANNUAL CONVENTION OF TINKERS? Of course or we would have just wasted a good story.

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The birthright of the rural mental health movement is that it has always been more than simply the delivery of standard mental health services to individuals and families living in a less densely populated context - as some urban based publications would have one believe. Rural mental health was born to a new mission that posited community as client and health as more than the absence of illness. It is true that scarce dollars and mounting needs have forced many of us from that original ideal. However, the emerging crises again remind us that our pioneers were visionaries, not just dreamers. So as we go back to the future we must realize that it is the role of the modern Tinker to stitch together the fabric of community. It is not enough to just heal, important as that is, or even prevent, but to enhance the quality of life of all residents is the rural mental health mission. And the sharp needle of the modern Tinker is leadership, leadership in shaping both mental health and social

familial growth and development that we all so highly prize as a core element in our rural environments.

The National Association of Rural Mental Health has historically been in the forefront of the movement to make policy responsive to the needs of rural citizens and communities. The NARMH board of directors under the leadership of Dennis Mohatt and now Ed Callahan has reemphasized this critical function and we salute their initiative and their industry in taking on this vital work. But even this talented and resourceful board cannot do that job alone. It takes a whole roomful, a whole convention of TINKERS to turn crisis into opportunity, to rearrange social policy so that it is responsive to the needs of rural residents.

Now some may say that smacks of political action and we are apolitical. In answer Joanne and I quote from Thomas Jefferson; "In a democracy where each individual's vote is supposed to be important, doing nothing is a political act."

So we again thank you and we are deeply grateful for the honor you have bestowed on us. But we also wish to challenge you. There is already clearly a crisis in the quality of rural life of

which managed care and welfare reform are but two immediate manifestations. In this room and in this organization are the persons trained and experienced in human behavior, organizational and community processes, scientific method, therapeutic strategy, family diagnosis and more. And you share a value system that prizes growth and opportunity, individuality and improvement, independence and self-reliance. So if the current rural danger is to be converted into rural opportunity, who in your community is better equipped for leadership than you? And if you do not accept his role, who will? And if not now, when?

Yes it is back to the future, rural is still a frontier, and fellow TINKERS, Wagons Ho!

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## Rural Community Mental Health

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