
rural mental health centers

MENTAL HEALTH SERVICES FOR ALL AMERICANS

the challenge of rural mental health

Jim Smith lived with his sister and her husband on their farm in the Midwest. He was a gloomy man, forever predicting war and depression, but he was a useful extra farm hand. Jim's fears became more and more unreasonable. He began to talk of "enemies" hiding in the tall grass in the rolling fields. Finally he became so terrified that he refused to go out of the house even in the daytime. Except at mealtimes he cowered in the darkest corners. Jim spoke less and less to anyone. Although his sister and brother-in-law tried, they failed to reach him or draw him into their activities. His condition continued to worsen, and the family sorrowfully concluded that he would have to be "put away." He was committed to the State mental hospital many miles away.

This story could have happened as recently as this year. Mental health facilities have been expanded and improved in the past 20 years but mainly in the cities.

In 1963, Congress passed the Community Mental Health Centers Act to improve mental health services for all Americans. Federal grants for staffing and construction are now available to help Americans develop high quality mental health services in or near their own communities.

Rural community mental health centers are developing, but many areas in need of services remain to challenge local leaders and States. By using Federal funds, they can develop local mental health centers so that Americans in outlying areas need not be

deprived of mental health services because of where they live or their financial condition.

To receive Federal assistance a center must make the following five services available to all persons in its service area: inpatient treatment, outpatient treatment, partial hospitalization (day or night care), emergency service 24 hours a day, and consultation and education to local agencies and professionals. Whether the services are situated at one or more locations, or provided by circulating staff members, they must comprise a unified program permitting continuity of patient care.

To qualify for a grant a center's service area should contain from 75,000 to 200,000 people, but there is no limit on the size of the area that may be covered. In the East where counties are small, some centers serve six or eight counties. In the West a single center serves a huge area in Weld County Colorado, and another, in Eastern Montana, serves 16 counties covering 45,000 square miles.

Rural Americans—Who Are They?

By Bureau of the Census definition, all those living in communities of 2,500 or less are considered to be rural Americans. In 1960 there were 54 million such people—30.1 percent of the U.S. population.

If people living in rural areas near large cities are not included, the figure drops to 45 million.

Rural Americans live in every State in the Union. They live in 2,160 predominantly rural counties which occupy about 90 percent of our land. A rural county is one distant from a large city, in which more than 50 percent of the population lives in rural communities. Some of these people live on isolated farmsteads or in very small villages.

Despite migration to the cities, the rural population increased by more than 8 percent from 1950 to 1960.

Rural communities vary widely but in general they have fewer health, mental health and other social

service facilities than do cities. Their income from taxes is generally lower because there is little industrial tax base.

Rural Mental Health Needs

There is no indication that rural people suffer any less than city dwellers from mental, emotional and personality disorders. In the general population it is estimated that one person in 10—one family in four—is affected.

Mental health needs have accumulated in rural areas where there have been no services. Rural populations have a larger percentage of children, old people and poor people who need care. Out of the 500 poorest counties in the United States, 486 are rural.

The development of facilities and personnel to help rural Americans is lagging. Only one in 14 rural counties has a general hospital with psychiatric facilities. In metropolitan areas the percentage is one in two or three. Only about 10 percent of outpatient psychiatric clinics are in rural areas and many of these are part-time. Of more than 16,000 psychiatrists who reported their place of work in an NIMH 1965 survey, only 500 were in rural counties.

In State plans for mental health centers which are developed in accordance with the Community Mental Health Centers Act, 90 percent of the States give first priority to areas containing rural counties.

What Is Being Done?

About one-third of the States are using Federal funds to help establish rural mental health services, but the real story of what is being done lies in the imagination and initiative with which they are tackling the problems. Here is what some rural communities are doing.

KENTUCKY—Citizens in this Appalachian area were challenged by the fact that their area includes two of the five poorest counties in the Nation. The local

mental health association, assisted by the State, conducted a survey to determine the needs. An NIMH demonstration project had earlier illustrated the values of mental health services. With encouragement and help from State mental health authorities, a local Board of Citizens was set up. A local minister devoted countless hours to explaining to community groups how a mental health center might help them and their families. The local board formed an organization, applied for Federal grants and worked out affiliation agreements with local agencies. Four widely scattered general hospitals provide inpatient and outpatient treatment, partial hospitalization, 24-hour emergency psychiatric service, and education and counseling services. The new program includes an information-screening-referral service operated by a mobile team of professional mental health workers. This gets people in isolated hollows to the right services without delay. The mobile team treats people, and provides parent-child, family life, and other counseling.

MINNESOTA—The Range Mental Health Center in Virginia, Minnesota illustrates public involvement in a program tailored to meet unique local needs. Basic services are provided by the Center and seven participating hospitals. These include such widely different special services as intensive care for alcoholics, and a program for children with learning disabilities. Two-way communication has developed between the Center and many local groups, some of which also participate in providing services on a referral basis. They include: public and Catholic schools and junior colleges, clergy, judges, lawyers, police and probation officers, correction agencies, the Minnesota-Youth Conservation Commission, physicians, nurses, hospitals, State employment offices, vocational rehabilitation service agencies, Indian Reservation personnel, industry and labor unions, Veterans Administration, Office of Economic Opportunity, local facilities for care of mentally retarded, sheltered workships, the State hospital, geriatric facilities and welfare departments.

NORTH DAKOTA—A combination of private resources, Federal aid and vigorous citizen action has enabled North Dakota to carry out a dynamic Statewide community mental health centers program. Three-fourths of the State's population is within an hour's drive of one of the five new centers at Bismarck, Fargo, Grand Forks, Minot, and Jamestown. The State passed a Community Mental Health Services Act which, for the first time, permits the counties to levy taxes to establish and support mental health and retardation services.

Adding a local tax base to the existing sources of State and Federal financing, has produced enough support so that North Dakota is experiencing little difficulty in recruiting qualified staff for its centers.

OKLAHOMA-KANSAS—State borders proved no barrier in setting up a mental health center serving five counties in Oklahoma and one in neighboring Kansas. The Center is operated by the Bi-State Mental Health Foundation, located in Ponca City, Oklahoma. The service program is offered mainly at Ponca City Hospital, and the Key Guidance Clinic. The hospital provides inpatient services, 24-hour emergency service, and special children's services. The Clinic provides outpatient treatment, consultation and education, diagnostic services, and precare and aftercare. The center serves an area of nearly 200,000 people. The Oklahoma State University, Hospital Clinic, Payne County Guidance Clinic, Child Welfare Services, and many other service organizations throughout the area participated in planning and development, and are integrating their programs to provide the services.

VERMONT—Two towns 50 miles apart, Newport and St. Johnsbury, form the nucleus of a mental health service program in rural Vermont. Operated as the Northeast Kingdom Mental Health Services, Inc., the Center serves an area of 48,000 persons. This is fewer

than the 75,000 minimum required for NIMH grants, but an exception was made because rough terrain and poor roads make travel difficult. Inpatient and psychiatric emergency services are offered at one hospital in Newport. The Center also operates two thrift shops (one in each town), and a sheltered workshop. It organizes volunteers for duty at nursing homes, and cooperates with local agencies including two Office of Economic Opportunity daycare centers for children. The program also features consultation and education for Red Cross workers, public health nurses, social workers, and police. In developing momentum and support for this program, clergymen, fraternal clubs, nursing homes, hospitals, professional and business people, and citizens were actively involved, and still serve on committees.

WYOMING—A highly mobile staff is a key feature of the community mental health program serving a five-county, sparsely-populated area in northern Wyoming. The population averages three per square mile. With headquarters in Sheridan and offices in each of the counties, the program serves a wide area with 45,000 people. A Sheridan hospital provides inpatient services—a nursing home in Gillette, partial hospitalization. A psychiatrist directs the program. A psychologist or psychiatric social workers in each county circulate to locations in the villages to provide outpatient care and consultation. Emergency psychiatric services are provided by a local hospital in each county. The center's staff is always available by phone. The local mental health association started the drive for a center program. The director, a psychologist who now serves as assistant director of the new Center, aroused the interest of a leading citizen who contributed funds to get underway. Together they organized local business, civic, communications, church and women's leaders to work for and support the Center.

Research And Training

The field of rural mental health presents many challenges to the research-minded professional. There is much that needs to be learned to improve understanding of the nature and extent of rural mental health needs.

Better ways to deliver the needed services need to be developed. NIMH grants are available for studies in these areas as well as for training and education programs. Here are some examples of recently funded projects.

UNIVERSITY OF WISCONSIN researchers are studying the 37 county mental hospitals in the State to assess the possibilities and processes by which they might be upgraded to provide short-term, early hospitalization to patients near their homes. This would reduce the need for commitments to more distant State hospitals.

THE NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH is conducting a continuing education program for rural physicians. A full-time psychiatrist travels from a State hospital base to five Appalachian rural counties where he sees physicians in their offices. Out of 68 practicing physicians in the area, 64 are participating. An unexpected byproduct is the reduction of State mental hospital admissions by 25 percent.

AT CORNELL UNIVERSITY in New York scientists are studying psychiatric and socio-cultural factors as they relate to rural mental health. Data are being collected on the incidence of psychiatric disorders. Inquiries are being made into the relationship between disorders and demographic and community variables in rural settings.

THE NEBRASKA PSYCHIATRIC INSTITUTE in Omaha is providing teaching and consultation to professional staff at the semi-isolated State hospital. A psychiatrist talks directly with staff members via closed circuit television. The staff member can discuss his patients' problems with the psychiatrist and receive guidance in handling them. During extra available hours of time television visits to patients are arranged. Relatives in the studio can see and talk with patients at the hospital. The station operates 44 hours a week.

A MONTANA STATE COLLEGE research team is gathering sociological information about 100 rural families of patients who have been admitted to the State hospital. The researchers seek to discover how communities in sparsely populated areas help their mentally ill before and after they are hospitalized.

THE NORTHLAND MENTAL HEALTH CENTER at Grand Rapids, Michigan is making a continuous and comprehensive rural epidemiologic study of an area containing 68,000 persons. Facts being discovered about mental illness in the area are used to improve the Center's treatment and prevention programs.

NEW ENGLAND'S high suicide rate has been the focus of a series of training conferences for community representatives from Maine, Vermont and New Hampshire. Under the auspices of the Department of Mental Health and Corrections in Maine, outstanding authorities on suicide prevention shared their knowledge with mental health personnel, clergy, police, welfare workers, and others.

THE KENTUCKY MENTAL HEALTH FOUNDATION at Louisville is providing continuous social work-nursing service in a remote, destitute mountain area. Preventable hospital readmissions were reduced,

periods of hospitalization were shortened, and patients remotivated and rehabilitated.

PRAIRIE VIEW HOSPITAL at Newton, Kansas has devised a low-cost, minimal followup service for released hospital patients, stressing group therapy and increased community concern. Careful evaluation is underway so that the program can serve as a model for other areas.

For further information, write to the Associate Regional Health Director for Mental Health at the DHEW Regional Office nearest you:

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The mental health needs of rural Americans are being met increasingly through outstanding local initiative and State and Federal financial and planning assistance. Successful rural mental health centers have used the Comprehensive Mental Health Planning or Area Wide Planning services available to them through Public Law 749, which includes the development of all needed health and social services. However, there is still a long way to go to meet rural needs fully.

By June 30, 1969, mental health centers funded across the country covered about one quarter of the total population, and about the same percentage of the population in rural areas. Of the 500 poorest counties in the United States, 486 are rural, and these are participating in the national community mental health program at the same rate as all rural counties.

Hurdles remain to be overcome before mental health services will be available to all Americans. More information based on research must be developed. Ways are needed to attract and hold qualified personnel, to develop local leadership, and to adapt services to rural needs. These are just some of the challenges which make rural America an exciting and rewarding frontier for expanding mental health research and services.

National Clearinghouse for Mental Health Information

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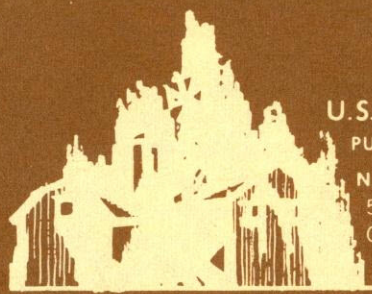

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