WORKFORCE DEVELOPMENT FOR RURAL MENTAL HEALTH

Student and Internship Models from the States

NOSORH
national organization of state offices of rural health

A Partnership activity of the

National Organization of State Offices of Rural Health

and the

Nevada State Office of Rural Health

National Center for Frontier Communities

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EXECUTIVE SUMMARY

The National Organization of State Office of Rural Health (NOSORH) developed a partnership project with the Nevada Office of Rural Health and the National Center for Frontier Communities (NCFC) to look at workforce development for rural mental health. The project consisted of two parts, a survey of all state offices and in depth case studies of three model programs; in Kansas, Nevada, and Virginia. This report presents a summary of the key findings.

From the survey, it was learned that 62% of states are working on mental health pipeline issues. And 72% report ongoing relationships with educational institutions and health professions training programs in their states.

One important finding was the large majority (78% of respondents) who replied that they either did not know or their state did not have a rural strategy in the state mental health workforce plan. This suggests that state offices have the opportunity to engage in workforce planning and a greater level of involvement can ensure the inclusion of specific rural mental health workforce goals. The SORHs are positioned to have access to health workforce data and strategies that target the mental health sector.

Only 22% of respondents replied that their mental health workforce information came from academia therefore suggesting that the training programs within their states perhaps do not have an established relationship with the SORHs. Of the 18 states that obtain workforce information from academia, it is significant that one-third indicated the Western Interstate Commission for Higher Education (WICHE, http://wiche.edu/) as their source for information. This demonstrates the important leadership role of WICHE in identifying problems and, more importantly, developing solutions for mental health workforce shortages.

SORHs should consider building a stronger link between their offices, state agencies and academic institutions.

Several unique examples of partnerships between SORHs, mental health agencies and programs emerged from the survey responses. These demonstrate the ability of SORHs to coordinate and collaborate across state administrative responsibilities and with education and training programs. This influential role has had a significant impact upon mental health planning and services delivery in the three states studied in depth and provide ideas for the rest of the country.

The three examples are very different and show the creativity of the SORHs in responding to the needs of their state. The Kansas SORH worked with Kansas State University to develop a Rural Family Helpline to provide telephone support to individuals and families. The Nevada SORH worked with University of Nevada Las Vegas and Great Basin College to provide professional services to at-risk youth and youth in the juvenile court system. The Virginia SORH facilitated a partnership with Radford University and FQHC's to train both primary care and behavioral health professionals in the successful integration of behavioral health into primary care practice.

The highlighted programs have each offered to help with replication. Promotion of these ideas and others could be further explored within the NOSORH by placing an exchange discussion on the SORH regional meeting agenda and at the annual meeting. This would provide opportunities for SORHs to share program ideas and address the organization's rural mental health services policy priority.

Part One – Creating a Baseline

Background

In March 2009, the National Organization for State Offices of Rural Health (NOSORH) solicited partnership proposals from state offices of rural health for projects that promote and champion a regional and national partnership that will benefit State Offices of Rural Health (SORH) and other national and regional organizations that address rural health issues.

The Nevada State Office of Rural Health submitted a proposal entitled, Workforce Development for Rural Mental Health: Student and Internship Models from the States. This proposal was accepted. The Nevada SORH goal was to simultaneously address two priority areas, health workforce and mental health. The Nevada SORH project was submitted as a collaborative with the National Center for Frontier Communities (Center).

As stated in the proposal, "SORHs have a long history of prioritizing rural mental health needs." The Nevada SORH has developed an innovative program to combine workforce development initiatives with improving access to mental health services. In submitting the proposal, Nevada would reach out to the other states to both share its model and learn what their colleagues were doing to address mental health workforce training needs.

The project would first and most importantly create a baseline describing SORH work on mental health workforce and secondarily highlight programs in other states.

Gathering Information from the States

An online survey was developed and distributed to the SORHs by the NOSORH State Director list serve. Information collected specifically addressed the mental health pipeline including the use of community members (i.e. *promotoras,* CHWs), students, interns and residents. The goal was to assess which states work with students, interns and training institutions and how many of the programs are currently providing mental health services in rural communities.

All (100%) of the SORHs completed the survey. The complete survey results are Appendix A, page 13. The survey responses provide a baseline of SORH interaction with mental health training and workforce issues in their state.

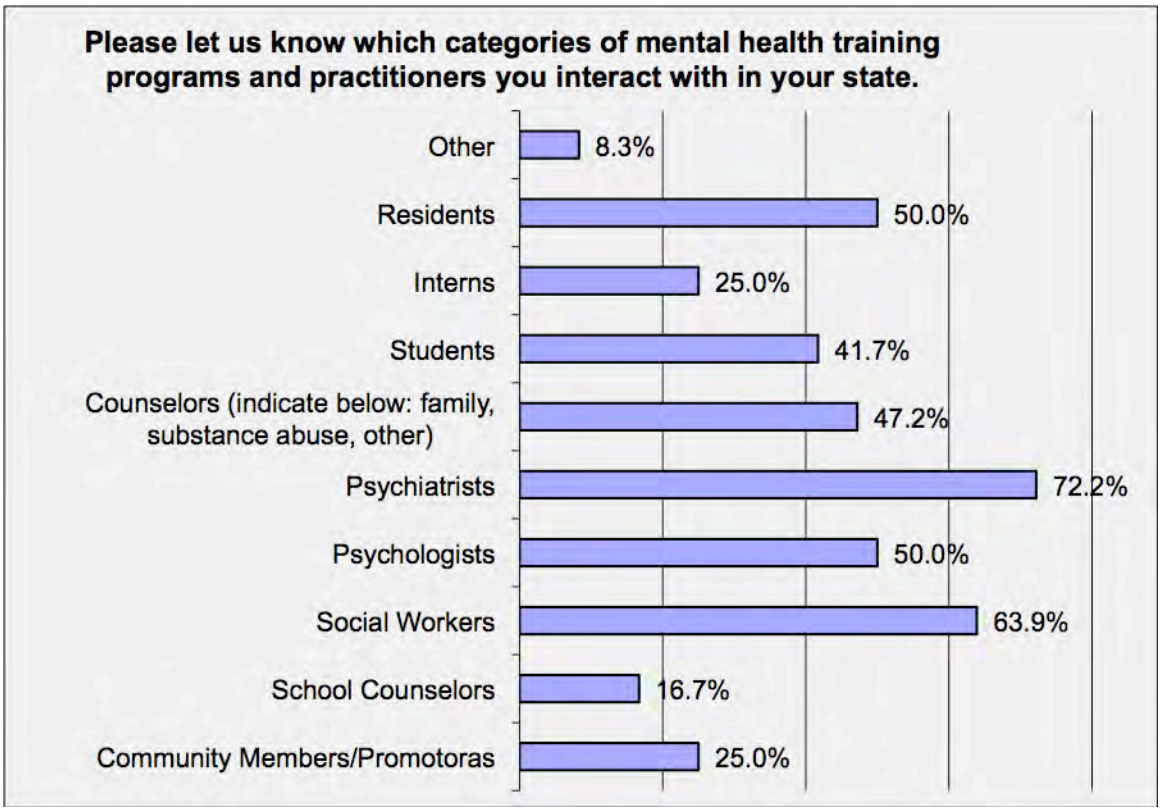
Key Findings

• Working on mental health pipeline and workforce issues?
YES = 62% (n=29) NO = 13% (n=6) DON'T KNOW = 21% (n=10) OTHER = 4% (n=2)

• Ongoing relationships with educational institutions and health professional training programs?
YES = 72% (n=34) NO = 13% (n=6) DON'T KNOW = 21% (n=10) OTHER = 13% (n=6)

• Types of educational programs and institutions.
2 year = 39% 4 year = 64% Graduate School = 21% OTHER = 23%

The response to this question showed a large number of programs at all levels of professional training and expertise. Table 1 below, from the survey shows the array of programs.



• These trainees interact with rural and frontier patients in a number of ways,
Rural based training program = 45%
Urban program with rural and frontier rotations = 39%
Telecommunications and/or Telehealth = 36%
Other = 32%

• State has a mental health workforce plan with specific rural issues and strategies?
YES = 13% (n=6) NO = 27% (n=12) DON'T KNOW = 51% (n=23) OTHER = 9% (n=4)

• Agencies contacted for information about rural mental health workforce issues.

	State Govt	Academia	NGO	Fed Govt	Other
Number = 81	42	18	14	6	1
Percent	52%	22%	17%	7%	1%
NOTE: Academia, 6 responses = WICHE Fed Govt, 2 responses = RAConline					

Three state offices of rural health - Kansas, Nevada and Virginia - provided information about programs in their state where the SORH directly participates with a rural mental health training program. These three states were selected for more in-depth study, which follows.

Part Two - Models and Case Studies from Three States

After reviewing the survey responses from the states, three states were selected for the gathering of more in-depth information. Those states are Kansas, Nevada and Virginia. Each office was sent a form to complete and telephone interviews were conducted. The submitted forms are found in Appendix B at page 25.

The three examples are very different and show the creativity of the SORHs in responding to the needs of their state. The Kansas SORH worked with Kansas State University to develop a Rural Family Helpline to provide telephone support to individuals and families. The Nevada SORH worked with University of Nevada Las Vegas and Great Basin College to provide professional services to at-risk youth and youth in the juvenile court system. The Virginia SORH facilitated a partnership with Radford University and FQHC's to train both primary care and behavioral health professionals in the successful integration of behavioral health into primary care practice.

KANSAS

Chris Tilden, Kansas SORH, recommended the Kansas Rural Family Helpline as an example of a model program that has a partnership with the state office. The Helpline is operated by Kansas State University. The relationship between the SORH and the Helpline is ongoing.

> *"The challenges facing people in agriculture often require special knowledge, special resources and cultural sensitivity. Kansas State Rural Family Helpline is dedicated to meeting those needs."* Charlie Griffin

Charlie Griffin, Director of the Kansas Rural Family Helpline and Assistant Research Professor, School of Family Studies & Human Services, was interviewed for this case study.

Sowing the Seeds of Hope Project - Kansas Rural Family Helpline

Background
In 2000 seven directors of Offices of Rural Health received federal funding to develop a seven-state coalition in the upper Midwest; Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin. The project was named Sowing the Seeds of Hope and its purpose was to provide public education, prevention programs and early intervention for rural behavioral health issues. This program is especially directed to meeting the needs of farm and ranch families.

The Wisconsin Primary Health Care Association administers the program. The Kansas Office of Rural Health contacted Charlie Griffin at Kansas State University, and based on KSU's past work with the 'farm crisis', asked him to develop a proposal. This initial funding led to the creation of the Kansas Rural Family Helpline based at Kansas State University. More information about the overall project is available at http://www.agriwellness.org/SSoH.htm and http://www.agriwellness.org/AWHistory.htm.

SORH staff has also served as a case management resource for callers to the helpline. Two areas of collaboration in particular have developed. One is working together to address the concerns expressed by rural families related to health care access and financial needs. SORH staff help identify resources to address these needs. The SORH has also increased the knowledge base of the Kansas State University Rural Family Helpline about the roles of federally funded community health centers and local county health departments. One other important collaboration is with the state-operated Agricultural FarmWorker Health Programs.

Project Link to Education and Training

This project is nominated for a case study because the Kansas program offers an important model providing education, prevention and early intervention with behavioral health issues. Culturally relevant interventions help minority, underserved populations overcome any hesitation to accessing "conventional" community services.

The Helpline is staffed by employees and, as funds permit, by graduate students from the marriage and family therapy programs at KSU. Students are also recruited from the new Personal and Family Financial Program. This program trains students as financial advisors to help individuals and families navigate difficult and changing financial situations. An important focus of this program is financial management and decision making within the family.

Student assistanceships have been primarily advertised within the School of Family Studies and Human Services, Marriage and Family Therapy (MFT) program. Information about openings is distributed to faculty and department offices. As faculty review and screen incoming graduate they refer students with a rural/agricultural background to Charlie Griffin.

Griffin is a guest lecturer in several key classes on professional studies for the MFT students, talking about rural mental health and the specific work of the Helpline. In the past, half time assistanceships, with subsequent training and experience have been funded. Ten students have participated. In the most recent two years, funds were not available for student assistants/interns.

The work at the Helpline has not been part of credit-based courses. Professional supervision and evaluation is on-going, focused on case management with additional skills and knowledge coaching by Griffin. Participating MFTstudents are able to count telephone based clinical hours as part of their overall MFT certification requirements. They have also received clinical supervision from faculty for Helpline cases.

Replication

This project can be easily replicated given appropriate resources and difficult to replicate without funding. The model and program components are easily replicable in both new and within existing programs.

Understanding cultural values of service populations is necessary to support a successful telephone Helpline and requires ongoing training. The actual service models are readily available. The development of policy and practice supports, which enable such models to happen successfully, is more challenging.

Student experience with the Rural Family Helpline has improved graduates´ choice of a rural practice. Two students have gone on into faculty positions with a strong focus on family based business (especially agriculture), finance, and family relationships. Two others are in professional therapy positions on staff in Community Mental Health Centers with large rural populations.

The Kansas State Office of Rural Health is willing to help other SORH's to establish a similar program.

NEVADA

Gerald Ackerman, Associate Director Rural Health Programs, Nevada State Office of Rural Health was interviewed for this case study.

> *"The Nevada Rural Mental Health Outreach Project can be easily replicated with states that have telemedicine capability and institutions of higher education with creative faculty."* Gerald Ackerman

Rural Mental Health Outreach Project

The project began as a concept for student rotations and evolved into distance training. Coordination of services was initially done through ORH. Currently, Communities in Schools, a private nonprofit organization is coordinating project expansion and the opening of new sites. ORH coordinates the tele-counseling network and works in collaboration with Communities in Schools to coordinate student rotations.

The project is nominated because its unique use of telecommunications/medicine provides rural and frontier training for urban based counseling students. The site is 7 hours from the University of Nevada Las Vegas (UNLV). Students develop new skill sets through this training and exposure to frontier and rural residents and communities.

Graduate students from UNLV provide counseling and undergraduate students in social work and the health services programs at Great Basin College provide case management.

Population Served and Training Sites
This program provides services to any youth in the juvenile court system. Training sites include juvenile detention centers and high schools. It also provides services to youth with learning disabilities and other issues that put them at risk.

The program takes participants on a first come first served basis and some participating communities already have waiting lists. For youth with suicidal/homicidal tendencies or ideation there is an immediate admission, no wait policy.

In the first six months of this program, thirty-six individuals received 255 hours of counseling. The program anticipates serving 150 young people in the first full year of operations.

Outcome Measurement
• Number of youth prevented from becoming offenders.
• Number of youth who finish recommended and/or court mandated counseling sessions.
• Number of professional students who participate and provide services through this program.

Replication
This project would be difficult to replicate without funding. Stipends of $15,000 per intern are offered for a fiscal year plus $5,000 for proctor oversight (for three interns).

The Nevada Office of Rural Health is willing for help other SORHs establish a similar program.

VIRGINA

Kathy H. Wibberly, Director, Division of Primary Care and Rural Health and Aileen Harris, Rural Health Workforce Programs Manager provided information for this case study.

> *"During our regional assessments, it became very clear that primary care providers, particularly those working in community health centers, reported that 50% to 70% of their patients were being seen with some type of behavioral/mental health issues."* Kathy Wibberly

Models of Care: Primary Care and Behavioral/Mental Health Integration

Background
This program was preceded by two earlier initiatives: 1) State-Level Rural Behavioral Health Assessment and 2) State Rural Health Plan Update.

Virginia took the State-Level Rural Behavioral Health Assessment a step further than requested. Using the tool-kit provided by NOSORH, Virginia added a component that included regional focus groups and assessments as part of the updated State Rural Health Plan. Rural Virginians identified behavioral health as major priority. Some of the key barriers to behavioral/mental health care in rural Virginia included extremely limited access to behavioral/mental health care and stigma.

Primary Care Integration with Behavioral Health
Primary care has long been considered a way of expanding access to mental health services, especially with the scarcity of mental health specialists in rural areas. Research has documented that rural physicians already play a greater role in providing mental health care than their urban counterparts. During the regional assessments, primary care providers, particularly those working in rural community health centers, reported that 50% to 70% of their patients were presenting with some type of behavioral/mental health issues. While many rural residents seek assistance through their primary care physician for a mental health condition, one study estimated that 50 to 80 percent are either not diagnosed or misdiagnosed.

As a result of this identified issue and priority, the Virginia SORH wrote planning funds into its SORH grant. These funds were used to help community-based organizations explore and plan for integrated models of primary care and behavioral/mental health. The purpose of the planning grants was to bring people together to cooperatively come up with innovative solutions to a significant rural health challenge. Additionally, the Virginia SORH contracted with a graduate student in psychology from rural Virginia to research existing integrated care models in the state. This research was presented at two conferences.

Integration Model – Kirk Strosahl
At the same time the Virginia SORH was looking at integration, it was contacted by the Southwest Virginia Community Health Systems Inc (SVCHS), a rural FQHC, inquiring about interest and/or funds to support training in the Behavioral Health Consultant (BHC) Model. This is a model of integrated primary care and mental/behavioral health developed by Kirk Strosahl. The Virginia SORH partnered with the FQHC to include a full day of training at the annual Rural Health Summit.

For more detailed information about Strosahl, his writings and consultation, his official website is http://www.behavioral-health-integration.com/news.php.

Partnership with Radford University
The SVCHS is currently implementing the BHC Model into their practice in collaboration with Radford University in Radford, Virginia. The collaborative focuses on the development of academic/clinical training objectives to prepare students to work in Primary Care-Behavioral Health Integrative Care. Three separate academic programs are involved; Clinical Psychology (PsyD), Counselor Education, and Clinical Social Work. The collaborative conducts clinical research related to health disparities and assessing the BHC model for both cost and therapeutic effectiveness with acute and chronic disordered patient populations in rural regions.

More information about the model and the training can be found at: http://www.va-srhp.org/2009-rural-health-summit.htm (see presentations entitled "Primary Care and Behavioral Health in Rural Virginia", "Integrating Primary Care and Behavioral Health Services: A Compass and A Horizon", and "Behavioral Health in Primary Care: Mastery of the Basics").

The Virginia SORH issued a request for proposals (RFP) for planning grants shortly before the Rural Health Summit and required all grantees to take part in the training at the summit. Because the SORH did not have the funds for implementation grants, it developed the RFP in partnership with the Virginia Health Care Foundation (VHCF). This assured that grantees who successfully met the requirements of the planning process were well positioned to apply for implementation funds through the VHCF.

Replication
This project is nominated because of the difference this model of care is making in rural Virginia and feel that if fully embraced it will change the nature of rural behavioral health care.

This project can be easily replicated. The promotion of integrated models can be done without funding. However, the actual implementation of these models is very difficult without funding.

The Virginia State Office of Rural Health is willing to help other SORHs establish a similar program.

Part Three – Next Steps

The National Organization of State Offices of Rural Health represents a diversity of organizational types and capabilities that create challenges in the development of a single plan for increasing state participation in rural mental health workforce planning as well as education and training programs. For example, ten offices are university based, three are independent private non-profit organizations, and thirty-six are within state government. Five offices were created in the 1970's, eleven in the 1980's and the balance in the 1990's. Many offices have two or fewer full time employees while others are quite large.

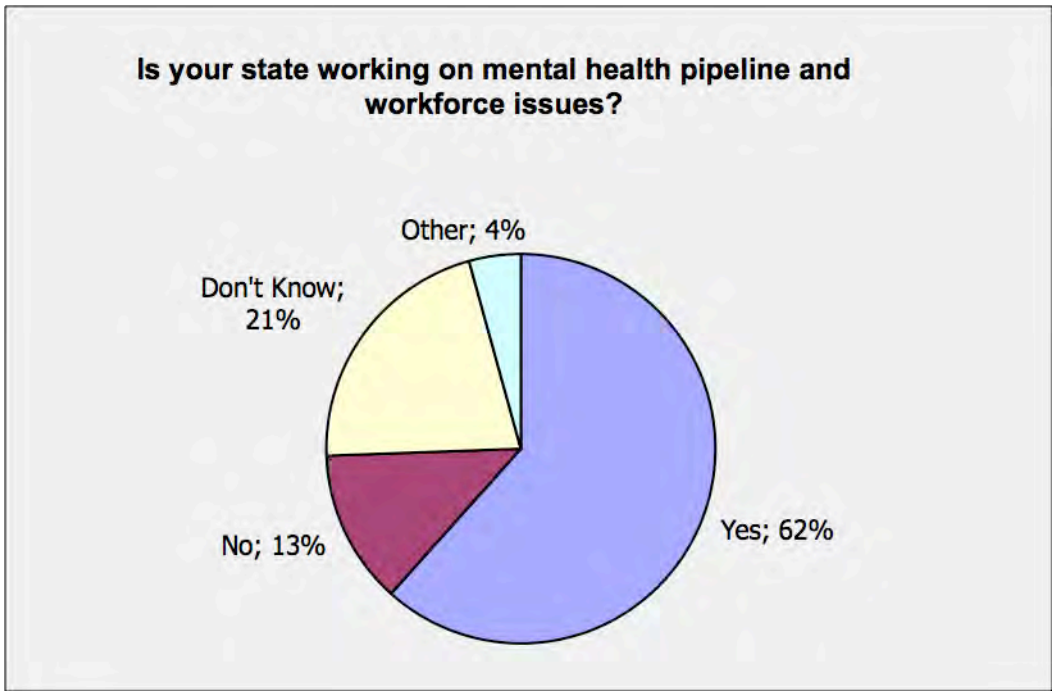
Because of this diversity several next steps are recommended for NOSORH.

1. Collect and disseminate federal and state mental health workforce plans that include specific rural strategies.
2. Encourage widespread adoption of the best models from existing rural mental health workforce strategies.
3. Create additional educational opportunities for the states to interact around rural workforce planning and initiatives that include rural mental health programs.
4. Increase advocacy efforts to federal and state policy makers to assure that State Offices of Rural Health are included in workforce planning, education and training programs.
5. Include rural Mental Health discussions and exchanges at the Regional SORH and Annual NOSORH meetings to provide ongoing opportunities to gain knowledge and strategize state, regional and national rural mental health system improvements.

APPENDIX A – The Survey Results

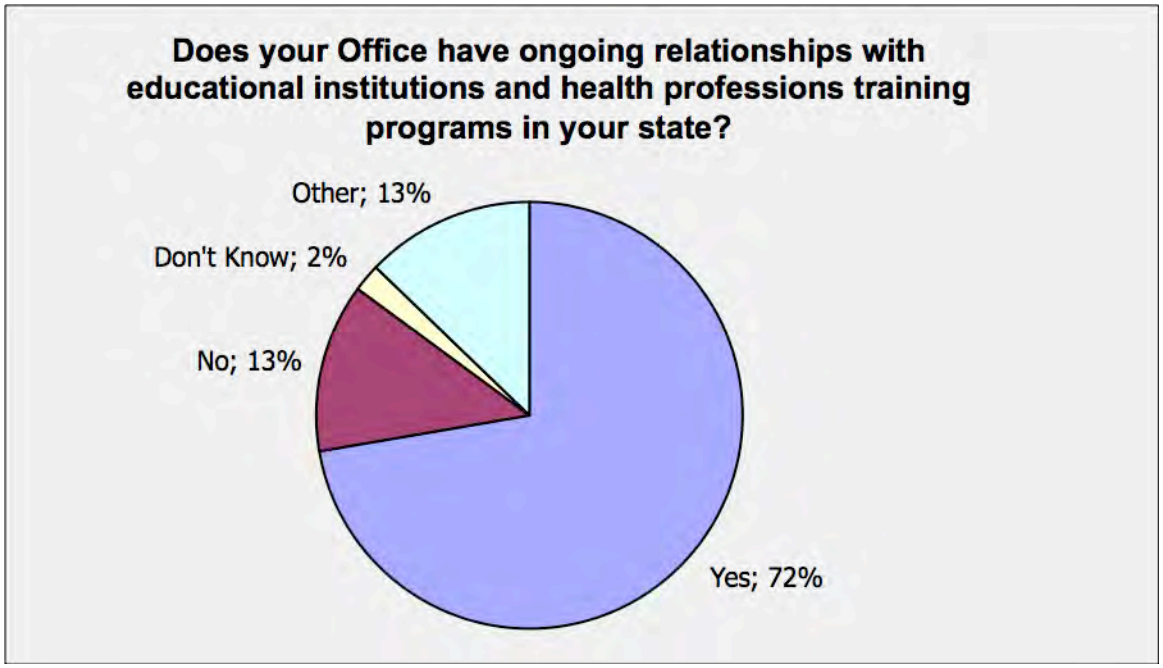
1. Is your state working on mental health pipeline and workforce issues?

Answer Options	Response Percent	Response Count
Yes	61.7%	29
No	12.8%	6
Don't Know	21.3%	10
Other	4.3%	2
answered question		**47**
skipped question		**0**



2. Does your Office have ongoing relationships with educational institutions and health professions training programs in your state?

Answer Options	Response Percent	Response Count
Yes	72.3%	34
No	12.8%	6
Don't Know	2.1%	1
Other	12.8%	6
Other (please specify)		13
answered question		**47**
skipped question		**0**

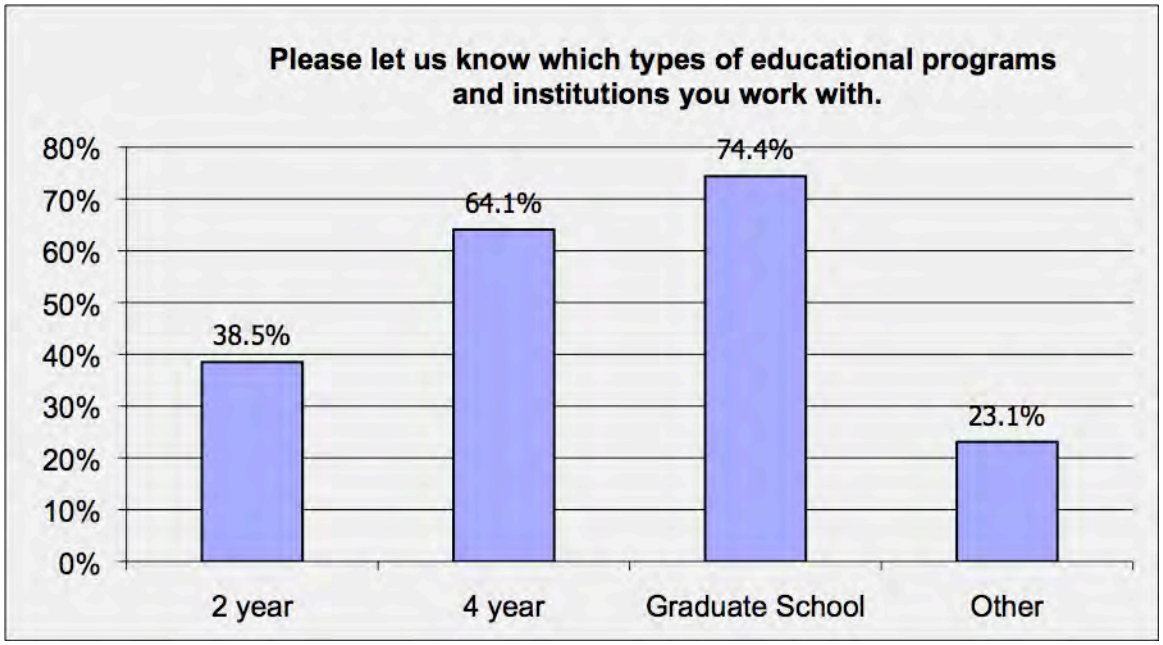


Other

We do our workforce assistance through the SLRP and NHSC Loan Repayment program
We have staff on the AHEC boards of the 2 AHEC programs in Iowa
Mental Health Professionals are part of the Health Workforce that our statewide Health Workforce Forum considers.
Especially those related to American Indians.
Not directly. Nebraska has a "rural student loan" program for graduate-level mental health students. We send notices and application forms to the Nebraska educational institutions offer programs in this area.
Other than including Psychiatrist in our MD/DO recruiting efforts, we do not currently work on Mental Health Workforce issues.
State Mental Health Agency
Through our SLRP, we work with the medical schools in three locations in New Jersey (North, Central and South). Our Community Workers/Navigators training activities are through the southern medical school.
In start-up phase
We have some interaction with health professional training programs but have limited dialogue with training programs in the behavioral health field.
Nevada System of Higher Education, University of Nevada, Reno, University of Nevada Las Vegas, Great Basin College, Western Nevada College
Yes, NC ORHCC has strong ongoing relationships with training programs and educational institutions - particularly in regard to recruitment and retention. Over the last 24 months, our office has housed a recruiter specializing in psychiatry and other mental health disciplines.
via our relationship with the state AHEC network

3. Please let us know which types of educational programs and institutions you work with.

Answer Options	Response Percent	Response Count
2 year	38.5%	15
4 year	64.1%	25
Graduate School	74.4%	29
Other	23.1%	9
Other (specified)		14
answered question		**39**
skipped question		**8**



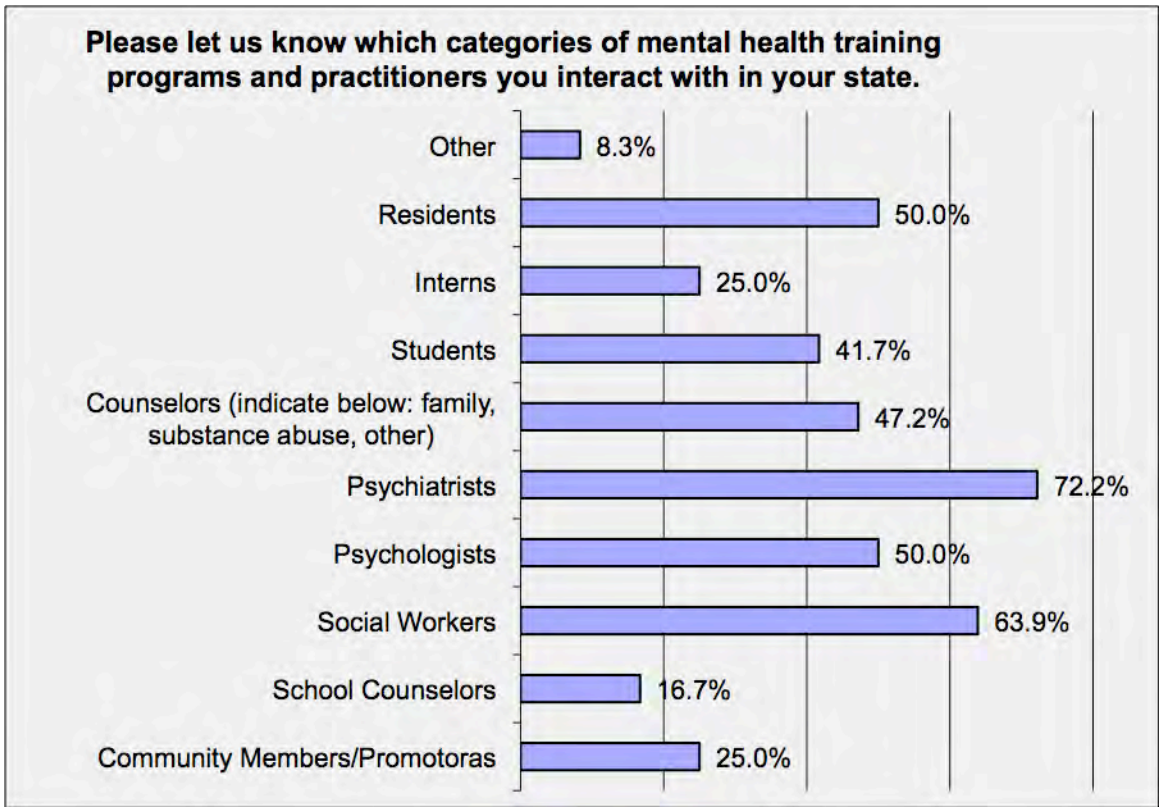
Other

thru AHEC
Medical School Residency Programs
We have statewide initiatives via our AHECS and through a recently created Health and Long-Term Care Advisory Council and the Direct Care Worker Advisory Council
I have ongoing relationships with the Schools of Social Work and the Licensed Clinical Professional Counselor (LCPC) program at University of Southern Maine.
Graduate medical education program
Tribal Colleges, 4 year programs and graduate health programs.
not sure exactly
none
Psychiatry Residency programs
School of Social Work in central NJ, Community Workers/Navigators and the Dental School. We worked closely with the central NJ medical school when we had the S.E.A.R.C.H program.

Professional schools
in start-up phase
Medical Schools, Dental Schools
Governor's Workforce Development Council

4. Please let us know which categories of mental health training programs and practitioners you interact with in your state.

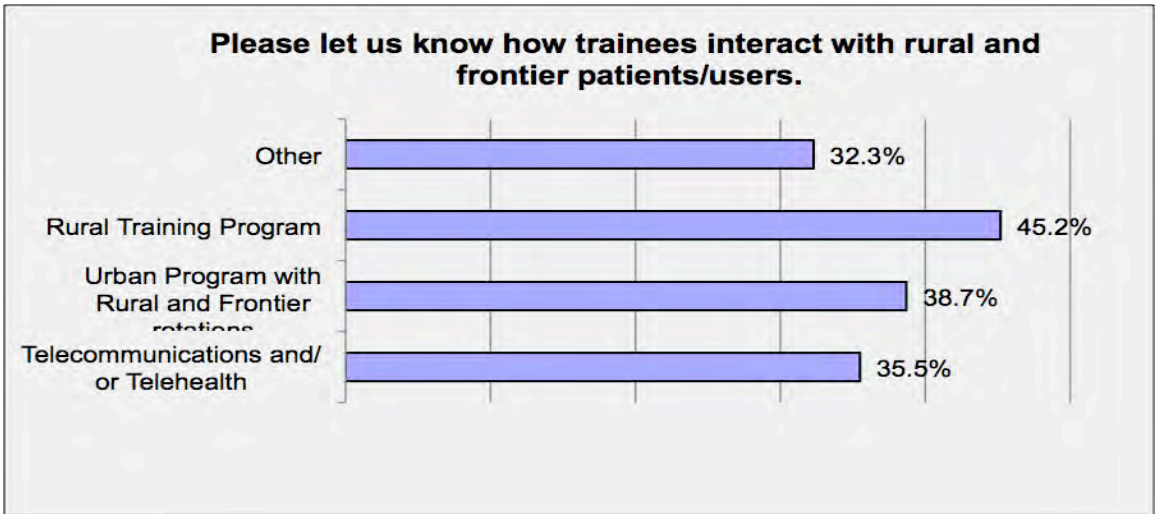
Answer Options	Response Percent	Response Count
Community Members/Promotoras	25.0%	9
School Counselors	16.7%	6
Social Workers	63.9%	23
Psychologists	50.0%	18
Psychiatrists	72.2%	26
Counselors (indicate below: family, substance abuse, other)	47.2%	17
Students	41.7%	15
Interns	25.0%	9
Residents	50.0%	18
Other	8.3%	3
Other		9
	answered question	**36**
	skipped question	**11**



Other
LPCs work in various fields - family, substance abuse, etc.
Direct Care Workforce
None
Licensed Mental Health Practitioner (LMHP)...the scope of practice of an LMHP is different than a social worker.
Family, substance abuse, marriage, LPC,
These are candidate that come through our recruitment service.
None
Some family and substance abuse counselors. School counselors only in conjunction with School Based Health Centers.
Behavioral Health Aides, family counselors, substance abuse counselors

5. Please let us know how trainees interact with rural and frontier patients/users.

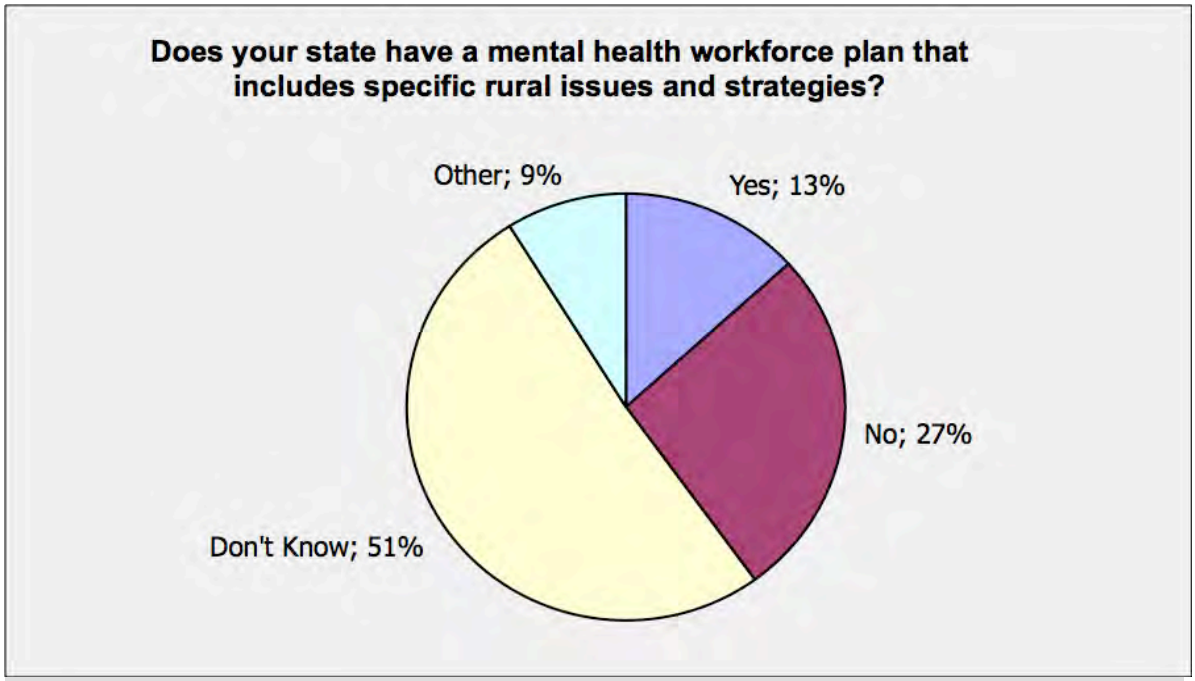
Answer Options	Response Percent	Response Count
Telecommunications and/or Telehealth	35.5%	11
Urban Program with Rural and Frontier rotations	38.7%	12
Rural Training Program	45.2%	14
Other	32.3%	10
Other (please specify)		17
	answered question	**31**
	skipped question	**16**



extreme minimal rural
We are starting discussion about supervision with trainees via telehealth so that they can be out in rural sites
There is not a focused effort on rural communities.
Don't know
One reservation has a psychologist internship. Master's level and doctoral students can be placed in rural, frontier, and tribal areas for field placements or internships.
not sure, something we are needing to find out more about.
I don't understand this question. Who are the trainees? I'm completely guessing at this...I've indicated all three of the above because we work with others on all three issues...but not always as related to mental health
Professional education funding program emphasizing rural/frontier placements.
MORE DETAIL ABOUT ANSWERS ABOVE: The SC Department of Mental Health was awarded a telepsychiatry grant through the Duke Endowment to provide all hospital EDs with access to psychiatric consultation through video communication. This is of course of particular benefit to rural hospitals/communities. Our state rural residency program in Seneca, SC has a behavioral health rotation component. Students from our University have various field placements and internships in mental health/substance abuse treatment agencies across the state.
Unknown
Some are in rural rotations
Most of our student rotations are in rural areas of state-defined rural areas.
through training opportunities in underserved areas
In start-up phase
This is what we're working on. At this point, we do not have a model.

6. **Does your state have a mental health workforce plan that includes specific rural issues and strategies?**

Does your state have a mental health workforce plan that includes specific rural issues and strategies?		
Answer Options	**Response Percent**	**Response Count**
Yes	13.3%	6
No	26.7%	12
Don't Know	51.1%	23
Other	8.9%	4
Other (please specify)		6
answered question		**45**
skipped question		**2**

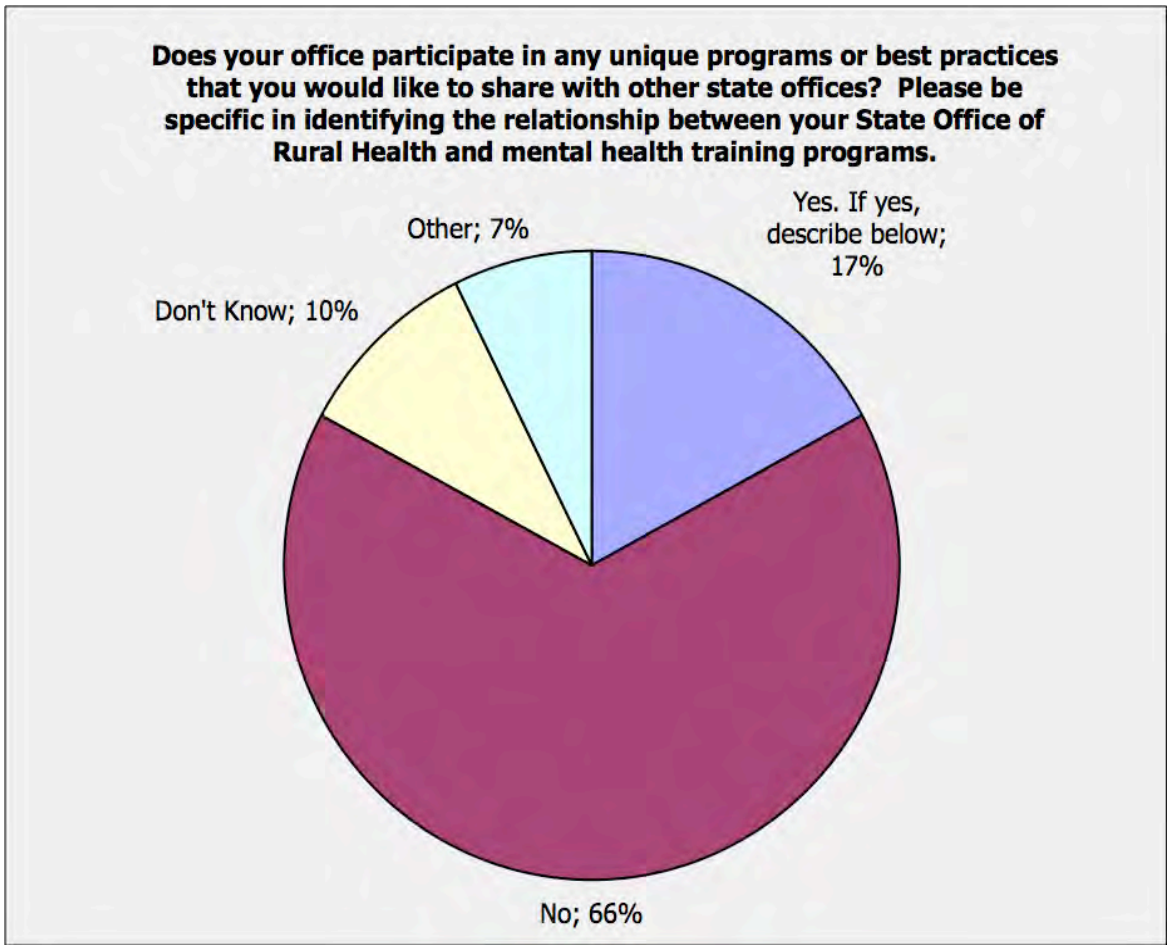


Other

We do not have a specific statewide document called a workforce plan, but we do have many organizations collaborating on mental health workforce issues
A process is presently being discussed
Nebraska has a "rural incentive" Act that address rural health care issues including mental health.
This plan is under the auspices of our Human Services Department.
In start-up phase
CT

7. **Does your office participate in any unique programs or best practices that you would like to share with other state offices? Please be specific in identifying the relationship between your State Office of Rural Health and mental health training programs.**

Answer Options	Response Percent	Response Count
Yes. If yes, describe below	17.1%	7
No	65.9%	27
Don't Know	9.8%	4
Other	7.3%	3
Other (please specify). If you answered yes, give a brief description of the program(s) and contact information for those programs.		11
answered question		**41**
skipped question		**6**



Other (please specify). If you answered yes, give a brief description of the program(s) and contact information for those programs.
Texas received a Mental Health Transformation Grant 4 years ago. The State Office of Rural Health is one of the Advisory Committee Members. Camille Miller with the Texas Health Institute is the contact person: (512) 874-7671 ext 5010 cmiller@texashealthinstitute.org
Radford University has a wonderful rural mental health PsyD program and we have been working with them. This is an issue we've been focused on this past year and have been exploring relationships with other schools. We also have a very nice model of integrated primary care and rural health. We put out two small planning grants for primary care and rural health integration this year and conducted training on it during our Annual Rural Health Summit as well.
Collaborate with Alabama Chapter of the American Academy of Pediatrics and the AL Dept of Mental Health to develop a model for delivery of pediatric mental health services in primary care settings through both conventional means and telemedicine.
Not unique, but we have funded adult mental health program.
Recently attended the 2009 SAMSA Policy Institute to eliminate disparities in mental health & substance abuse. Working with state MH agency and other partners to remove barriers to the use of telehealth for delivering MH & SA services.

New Mexico Health Professional Loan Repayment Program - providing loan repayment for health professionals, including behavioral health professionals, in exchange for commitments to work in rural/frontier areas. New Mexico Health Service Corps - providing stipends to health professionals, including behavioral health professionals, during their clinical training in exchange for commitments to work in rural/frontier areas. Rural Health Practitioner Tax Credit Program: providing state income tax credits to health professionals, including behavioral health professionals, working in rural/frontier areas.
Our office works with the Community Mental Health Clinic Council
I don't know that the Nebraska rural incentive programs are different or unique but mental health practitioners (or students) are included in both the Nebraska (rural) Student Loan Program and the Nebraska Loan Repayment Program. The only difference I'm aware of is that the Nebraska rural incentive Act requires practitioners to practice "mental health" not social work so our regulations and statutes refer to the scope of practice of the practitioner.
Our office has provided support and some financial assistance to the Farm Stress Network out of Kansas State University that utilizes students for some of their work. We also have been involved in planning of the state behavioral health services response network that provides training to volunteers who provide crisis support in emergency situations.
We are currently working with University of Nevada, Las Vegas Department of Counseling, Community in Schools and Juvenile Probation to provide counseling services to at risk and youth on probation utilizing Graduate students.
My office is responsible for coordinating the statewide Comprehensive Integrated Mental Health Plan, which includes information on mental health workforce. We collaborate with other divisions in the Department of Health and Social Services, the Alaska Mental Health Trust Authority, and state wide boards such as the Alaska Mental Health Board. The person on my staff who coordinates the Comp Plan is Jean Findley, jean.findley@alaska.gov 907-465-8652. Also, I have a staff member who serves on the Community Health Aide Certification Board. This group has undertaking a certification process for Behavioral Health Aides. Faith Allard is the contact person; she is also the Flex Director. faith.allard@alaska.gov 907-269-3456

8. Respondents

Charles Lail	Director, Office of Primary Care & Rural Health	AL
Pat Carr	Director, Alaska Office of Rural Health	AK
Bill Rodgers	Director, Office of Rural Health and Primary Care	AR
Brian Woods	Chief, Primary Health Services Dev. Programs	CA
Cari Fouts	Program Director	CO
Barbara Berger	Director	CT
Katherine Collison	SORH Director	DE
Bob Pannell	Director	FL
Charles Owens	Executive Director	GA
Gloria Wong	Chief	HI
Stephanie Hansen	Health Program Specialist	ID
Julie Casper	PSA	IL
Doreen Chamberlin	Bureau Chief , Health Care Access	IA
Chris Tilden	Director, Local and Rural Health	KS
Larry Allen	Director, Kentucky Office of Rural Health	KY

Gerrelda Davis	Director of BPRCR	LA
Charles Dwyer	Director	ME
Michelle Clark	Project Director, SORH	MD
John E Barnas	Executive Director	MI
Jill Myers	Rural Health Planning & Analysis Mgr	MN
Barbara Brendel	Rural Health Coordinator	MO
Dennis Berens	director, state office of rural health	NE
Tom Rauner	PCO Director	NE
Marlene Janssen	Health Program Manager	NE
Gerald Ackerman	Assistant Director	NV
Alisa Butler-Druzba		NH
Linda D. Anderson	Coordinator Office of Primary Care/Rural Health	NJ
Justine Ceserano	Director	NJ
Harvey Licht	Director PCRHO	NM
Tammy Norville	PCO Coordinator/Primary Care Systems Specialist	NC
Jacque Gray,	Assistant Professor	ND
Karen Madden	Director	NY
Ann Alley	Director	
Val Schott	Director, Rural Health Policy & Advocacy	OK
Robert Duehmig	Communications Director	OR
Lisa Davis	Director	PA
Carla Lundquist	Acting Chief, Office of Primary Care & Rural Health	RI
Stacey E. Day	Director of Recruitment	SC
Halley Lee	Manager, SD Healthcare Workforce Center	SD
Patrick Lipford	Director, State Office of Rural Health	TN
Theresa Cruz	Director, State Office of Rural Health	TX
Kathy Wibberly	Director, Div of Primary Care & Rural Health	VA
Kris Sparks	Director Office of Rural Health	WA
Shawn Balleydier	Assistant Director	WV
John Eich	Director	WI
Jeff Hopkins	Office of Rural Health	WY
Marilyn J. Patton	Community Services Coordinator	WY

9. **Which agencies do you contact when you need information about rural mental health workforce issues?**

The table below shows the aggregated totals based on the larger table that follows with the individual responses.

	State Govt	Academia	NGO	Fed Govt	Other
Number = 81	42	18	14	6	1
Percent	52%	22%	17%	7%	1%
NOTE: Academia 6 = WICHE		Fed Govt 2 = RAConline			

Responses
Department of Behavioral Health
This is not something we are involved in now specifically for mental health (we do, however, work on workforce issues in general), but I would be interested in seeing what other states do.
Texas Department of Criminal Justice, Texas Department of State Health Services
National Rural Mental Health Association, American Psych Association, NIMH, SAMHSA, WICHE
Illinois Department of Healthcare and Family Services, Division of Mental Health and the FQHC's, and local health departments.
Missouri Department of Mental Health, Comprehensive Psychiatric Services or Missouri Department of Mental Health, Alcohol and Drug Abuse Unit.
WICHE, RUPRI, Universities and associations in Iowa that deal with mental health issues and professions.
AL Dept of Mental Health
Adult Mental Health Unit, Department of Health and Human Services
Hawaii Dept. of Health. RAConline.
State MH agency
Northern NY Behavioral Health Care Network, NYS Office of Mental Health
Aberdeen Area Indian Health Service, Aberdeen Area Tribal Chairs Health Board, North Dakota Department of Human Services, Mental Health American in North Dakota
Colorado Behavioral Health Association
State Mental Health Administration
Related licensing boards (Board of Psychology, Board of Social Work, etc), related educational institutions, Department of Human Services, Community Mental Health Centers, U of M's Center for Rural Mental Health.
HRSA
National Association for Rural Mental Health
The Community Mental Health Council, University of Arkansas for Medical Sciences, State License Boards
University of Nebraska Medical Center, Health Professions Tracking System; UNMC College of Public Health; UNMC Menroe Meyers; Nebraska Division of Behavioral Health; WICHE Mental Health Program; Health Workforce Information Center
University of Nebraska Medical Center; Munroe-Meyer Institute; professional associations
Area Health Educational Centers, Lugar Center for Rural Health, I.U. School of Medicine Division of Mental Health and Addictions/Family Social Services Admin/State of Indiana
Mental Health and Substance Abuse Division
The South Carolina Rural Health Research Center (SCRHRC), South Carolina Department of Mental Health, (resource for hard data: Office of Research and Statistics/SC, State Budget and Control Board)
Our local contract mental health centers, and the WICHE Mental Health Program.
WV Office of Behavioral Health and Health Facilities
Our primary focus has been primary care and we have not mental health.
Kentucky River Community Care Inc.
Department of Human Services, Division of Mental Health
NJDHS
We've never needed to contact an outside agency for information. We are co-located with the Primary Care Office and have access to shortage information. The entire state of Idaho is a geographic health professional shortage area in area of Mental Health.
Kansas State University, WICHE

SD Department of Health and Human Services, SD Department of Social Services, SD Board of Regents
Maine Rural Health Research Center, WICHE Center for Rural Mental Health Research
AHEC, University of Washington
Various. State Division of Mental Health
Governor's Workforce Development Council
Mental Health LME contacts w/in particular area we're working on.
Department of Mental Health and Addiction Services
Alaska Mental Health Trust Authority, Alaska Department of Health and Social Services/Division of Behavioral Health, Alaska Behavioral Health Association, University of Alaska - masters in SW and psychology BA-PhD departments. Univ of Alaska Office of Statewide Health Programs
Raconline, NRHA, NOSORH, New England Rural Health RoundTable

APPENDIX B

Each of the three states selected for more in-depth information, Kansas, Nevada and Virginia, completed the following form.

KANSAS	
Start Date	2001
Completion Date	Ongoing.
Partners	The Kansas Office of Local and Rural Health are a partner and member of our advisory group. Kansas Agricultural Mediation Service Agribility-USDA funded program for farmers/ranchers with disabilities. Kansas State Extension Service Kansas Ecumenical Ministries Other universities and community colleges in Kansas
Funding	Since the first few years of congressionally directed funding, we have continued coalition development with a variety of individual state funding coupled with Office of Rural Health Policy Outreach and Network development funds. Each state has their own unique state-funding base coupled with some shared funding and resources.

Participants	The Kansas Helpline is staffed with both employees and at times student assistants and interns at Kansas State University. Staff is trained, helping professionals who can provide short term emotional support, competent advice, and qualified referrals. Our staff addresses the ongoing issues facing today's farm and rural populations. We collaborate with local, state, and national resources to assure efficient coordination and address the challenges confronting our states rural residents. The Family Studies and Human Services Program of Kansas State University operate the Helpline.
Setting	Kansas State University provides the space for the helpline. Most services are provided over the telephone through the helpline Partners and referral resources involve a great variety of participating entities across the state as need dictates and funding permits. Training workshops take place on a community level.
Recruitment	Turnover is low. Full-time staff person has been on the job for 20 years. Recruitment of graduate students from marriage and family therapy programs at KSU happens as funding permits. Students are also recruited from the new Personal and Family Financial Program, which consists of education and advisement regarding financial issues. Focus is on decision making in the family. Students are trained to become financial advisers in this area.

Recruitment Problems	Lack of adequate funding.

Supervision	My role as program director involves both admin/ on-going program development as well as supervision of staff who handle casework. We work collaboratively quite actively with state mental health resources, SORH, ag production, legal, financial, mediation services, etc.

Services	The Helpline provides confidential, short-term emotional support, competent advice, and qualified referrals directly to rural families struggling with an unmet emotional, medical, financial or legal need. Basic function is as a toll free telephone based assistance program. All aspects below, however, may come in to play at some time: Outreach Training and education: community education Clearinghouse for behavioral health related information as referral Crisis Hotline Emergency funds to support behavioral heal and other service needs via 'vouchers' in collaboration with the Kansas Ecumenical Ministries Prevention/Early Intervention through a variety of community awareness, trainings, etc. Coalition Building—assist in development of coalitions with a common focus on rural needs Advocacy Retreats/Support activities
Providers	The Helpline support team combines an understanding of the unique needs of rural communities with professional training in family assistance. The Helpline will provide continuing support and expanded services by partnering with other agencies, public and private, which share the mission of serving the unmet needs of rural families by providing financial and other resource assistance. KRFH staff provides the basic information, referral and follow-up support, however referrals and collaborative casework involve many different providers.
Population Served	Services are promoted to 'rural' and 'farm and ranch' callers. Basic info and referral to anyone who calls. No fees and no eligibility requirements.
Number Served	From Agriwellness annual report http://www.agriwellness.org/annreport08.pdf Time frame: November 1, 2007—October 31, 2008 Provided community education 18,266 persons, education retreat services to 357 persons, and trained 697 professional providers. Responded to 16,590 helpline calls from rural areas

	Made 422 outreach contacts Provided 4,314 vouchers for behavioral health services to rural people Disseminated 29,844 pieces of information through marketing efforts and 8,270 through information clearinghouses.
Significant Results	Sensitivity to rural/frontier populations/issues….we have both offered a 'farm-friendly' service, but often are in the position to educate and improve awareness and quality of service provision for other human service providers in a more culturally effective manner for ag and rural services. Additionally, we often help interpret, coach, give consumer education, etc to rural people as they maneuver their way through other services who are not so farm friendly
Outcome Measurement	Primarily data collection, but we do not utilize any specific outcome based measures in follow-up.
Additional Data	can provide

NEVADA	
Start Date	October, 2008
Completion Date	Ongoing, Recent expansion to Humboldt County Will continue as long as possible.
Partners	Communities in Schools University of Nevada Las Vegas-Dept of Counseling Education Great Basin College Juvenile Probation Americorps VISTA School Districts
Funding	Original funding was partly from State Board of Communities in Schools. Tobacco Settlement (funding ended 6/30/09 United Way Private Donations Project has several grants out related to mental health.

Participants	Graduate Students from UNLV provide counseling services; undergraduate social work and health services students from Great Basin College provides case management.
Setting	Juvenile Detention Centers High Schools Graduate students are proctored by staff on campus Other sites are being set up for non-offending youth Depends on where telecommunication equipment is available

Recruitment	Graduate students are recommended by faculty. Larry Ashley, Professor in Residence at UNLV is the Undergraduate Coordinator for the project. Students become his grad assistants and he becomes their proctor. Great Basin College faculty also recommends, but there is more word of mouth recruitment. Students are given this project as a choice when choosing their required community project.
Recruitment Problems	Difficult to recruit students during the summer months.

Supervision	Onsite for graduate students. Professor Larry Ashley for rural areas out of UNLV. Katrina Harris, Internship Coordinator for Las Vegas and urban areas. Undergraduate students are supervised by CIS, who provides feedback to the GBC professor that recommended them.

Services	Clinical assessments and mental health counseling
Providers	Students from the Dept of Counseling, UNLV, coordinated by project partners. Roles are agreed upon in Letter of Agreement between partners.
Population Served	Any youth in juvenile court system Youth with learning disabilities or other issues for non-offenders. Population is Diverse. Project operates on first come first served basis, waiting list in some communities, exception would be experiencing homicidal/suicidal tendencies. State now requires assessments on all participants in juvenile court system.
Number Served	36 individuals received 255 hours of counseling from Oct 2008 through June 2009. Anticipate 150 participants this fiscal year.
Significant Results	Rural population now getting services. Exposure to frontier areas. Practice opportunities and skills building for students.
Outcome Measurement	Number of youth kept from becoming offenders. Number of students who finish counseling sessions. Number of students who receive training.
Additional Data	Will send

VIRGINIA	
Start Date	Conceptually it began in Fall of 2007 with our Rural Behavioral Health Assessment and continued into 2008 with the RFP for Planning Grants and the 2009 Rural Health Summit.
Completion Date	Ongoing—No End Date
Partners	I guess you could say we are both a lead and a partner. We are a lead in drawing attention to the concept of primary care and behavioral health models. We are a partner in facilitating its implementation in rural practice settings.
Funding	The planning grant effort is partially through SORH Grant, the training at the Summit was partially funded through our FLEX grant with assistance from Radford and Southwest VA Community Health Systems Inc. Funds for implementation of new models of care are being made available through our partnership with the Virginia Health Care Foundation.
Participants	We used a graduate student in the clinical psychology program at a local university to conduct our assessment and to do research on models in Virginia. See attached poster from our presentation at NRHA to see the integration models that exist in Virginia.
Setting	Southwest Virginia Community Health Systems Twin City Medical, Saltville & Tazewell Community Health Clinics
Recruitment	Participants are recruited by the academic institution, the community, the SORH. Planning grantees were recruited through the RFP process.

Recruitment Problems	There was some concern by Community Services Boards (our public mental health system) during the training that this was indirectly saying that they were not effective in doing their jobs. However, the reality in Virginia is that in rural areas, the CSBs only have the manpower to address the needs of the severely mentally ill. However, effective recruitment (e.g., obtaining buy-in) needs to consider and address these concerns. Additionally, to expand the training model, training and supervision and advocates/champions for the model are needed. We are fortunate that several such models already existed in Virginia. For example, the Radford University Doctor of Psychology (Psy.D.) Program has a rural mental health emphasis. Because rural residents tend to seek care from physicians rather than mental health professionals, the Program faculty have been exploring how to include integrated care into the program. Based on their own work as well as participation in the activities described herein, they have implemented the following: (a) The Health Psychology in Rural Areas course was moved from the Summer of year 2 to the Summer of Year 1 to prepare students for placement at medical sites in their second year of practicum; (b) One of the books used in the Health Psychology course is on integrated care; (c) The Program will be sponsoring a regional counseling psychology conference in the fall of 2010 and integrated care will be one of the tracks of the conference; (d) The Program faculty are talking with Counselor Education and staff at SVCHS about sponsoring a conference in the Spring of 2010 or 2011 focused on integrated care; (e) The Program Director serves on the Board of Directors of the local Mental Health Association and has been discussing collaborating on integrated care initiatives; (f) First year Psy.D. Program students and some Program faculty will be staffing a Wellness Center developed by the Mental Health Association and if funding is received the Center will be expanded to provide services by students in other graduate training programs (e.g., Occupational Therapy, Mental Health Nurse Practitioners, Counselor Education, Social Work); (g) Program faculty serve on the Boards of Directors of two groups planning on developing FQHCs in the area and integrated care is anticipated to be part of both centers (one of them may place a special emphasis on behavioral care) with second and third year Psy.D. students identified as the service providers; (h) A second year student will be doing her practicum placement at a FQHC in Roanoke and there have been discussions about students doing this at other established sites in the area;

	(i) The Program Director serves on the Board of Directors of the Virginia Rural Health Association (VRHA) and has been discussing ways of including integrated care discussions in VRHA-sponsored events such as this fall's annual conference; (j) Faculty have been discussing tele-supervision and will be talking with the Northern Neck Middle Peninsula Telemedicine Network about possibilities; (k) Finally, there is the possibility that students will be placed at sites providing integrated care for their year-long capstone internship if funding is available. Supervision in rural areas is a barrier because students interested in this model would need to have supervision while they are at a practice site. Virginia is exploring the concept of using telehealth and establishing processes for remote supervision. We are also in the very early stages of engaging in some dialogue with the American Psychological Association to see if there might be some interest in partnering with us to develop a more rurally focused psych training model.

Supervision	Not really applicable. Those who have implemented integrated models work with their own staff and partners for supervision. The Virginia SORH is only responsible for ensuring that the efforts of the planning grant recipients are making progress. The Virginia SORH does see as its role facilitating partnerships. For example, the Northern Neck Middle Peninsula Telemedicine Network is looking into using their videoconference equipment to meet some behavioral health needs at the same time that Radford University is looking to expand their new rurally focused PsyD program. The Virginia SORH is working facilitate a linkage between these two efforts.

Services	We funded the assessment process and the research on models, offered education about models, helped people to network, provided training in one particular model and provided some funds for planning purposes for those interested in the model.
Providers	Community based organizations and academic institutions are the primary providers in terms of implementing the model. As mentioned earlier (refer to the NRHA poster), several models exist and are being implemented.
Population Served	All
Number Served	Over 1000 patients were served in the last year through SW Virginia Community Health Systems
Significant Results	It has increased interest in replication and using the model!
Outcome Measurement	Increased interest and implementation of integrated models of care statewide. A Pilot Study Program has just been completed, through Radford, involving 300 patients. A complete report is available at Virginia State Rural Health Plan website http://www.va-srhp.org/docs/integrated-behavioral-health-care-study.pdf
Additional Data	Not yet, other than results from the assessment which was presented during a NOSORH webinar and available in report format and the poster session provided at NRHA. We will have planning grantee final reports later this summer/early fall