Rural Mental Health Counseling:
One Example of Practicing What the Research Preaches

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ABSTRACT

Among rural Americans, the prevalence of mental illness is notable and accessibility to mental health services is difficult. There are many barriers existing for individuals living in rural areas regarding receiving mental health services and difficulties faced by mental health professionals serving this rural population. In this manuscript, a literature review was conducted outlining the issues faced by recipients and providers of mental health care. Also, a community counseling and training clinic is described. The efforts of this clinic focus on training counselors for practice in rural areas as well as addressing the problems described in the research literature as barriers for rural individuals receiving mental health care.

INTRODUCTION

The first part of this manuscript seeks to outline significant issues plaguing rural mental health care. These issues consist of problems faced by recipients of mental health care as well as challenges for practitioners in rural areas. In the second part of this manuscript, the author will discuss one community’s attempt to mitigate these issues by putting research into practice in the form of a community counseling clinic, which also serves as a training clinic for students in a master’s level counseling program.

Issues in Rural Mental Health

It is widely known that mental disorders are common across the United States. Mood disorders, schizophrenia, anxiety disorders, eating disorders, suicide, attention deficit hyperactivity disorder (ADHD), autism, Alzheimer’s disease and other diagnosable mental disorders affect approximately 22.1% of the American population age 18 or older (NIMH, 2000a). One quarter of the population of the United States resides in rural areas. Nearly 60 million rural Americans experience rates of mental illness, substance abuse, emotional disturbance and disability equal to or greater than people in urban areas (NIMH, 2000b). Because of stressors characteristic of rural areas such as low or insufficient income, single parenting, lack of employment opportunities, and lack of or inaccessible community resources, opportunities for receiving mental health assistance may be sparse. More often than not, those living in rural areas have to travel long distances for services. Even when these individuals are able to get to a town where mental health services are offered, they may not be able to pay for existing services, may not get the help they require, or may end up at the hospital having waited until they are in a crisis situation. Often mental health services received by people from rural communities are provided by general medical practitioners in hospitals and private clinics (National Rural Health Association, 1999). However, care by public facilities for those in rural areas who experience mental illness has been found to be inconsistent and unreliable (Blank, Fox, Hargrove & Turner, 1995). These obstacles encountered by those living in rural communities suggest that effective care is multidimensional and that care must be provided in a consistent and accessible manner.

Research indicates that one out of five rural individuals has no health insurance (APA, 2000). Without insurance coverage and even with assistance, co-payments on psychoactive medications are very
expensive for families who are struggling to pay electricity and food bills as are psychiatric care and psychotherapy. If health insurance is available, the benefits may not include many sessions of psychotherapy or may not include therapy as part of the benefits at all. Also, only 25% of the rural poor are covered by Medicaid compared to 43% of the poor in inner cities (NIMH, 2000b). The state of Montana has one of the lowest median household incomes in the country at $33,024 and the percentage of people who live below poverty level in Montana is 14.6 which is above the national poverty average (12.4%) (U.S. Bureau of the Census, 2000). Due to the often insurmountable nature of financial hardship, adults, families, couples and children who are low-income likely function under a great deal of ongoing stress. Many of these families have Medicaid or no health coverage at all. In Montana, Medicaid has recently amended their mental health coverage and will only cover eight sessions of psychotherapy in six months. There are numerous effects of this cutback. One effect is that those with severe mental illness may not receive consistent services that are necessary in order to maintain healthy functioning. Another effect is that these individuals may end up in crisis situations that could have been avoided if they were receiving consistent care. Therefore, hospitals and law enforcement are often stressed by a high level of involvement in mental health issues (i.e., dealing with suicidal persons, psychosis, etc.).

Rural Cultural Values Regarding Mental Health/Illness

Many individuals living in rural America hold stereotyped views or lack education regarding mental illness, therapy, psychotropic medication, or mental health care in general (i.e., NIMH, 2000b). It is unclear why such stigma is so pronounced in rural areas but such views as well as lack of education may in part be due to insufficient resources, isolation, and the value of autonomy (e.g., Kelleher, Taylor, & Rickert, 1992; Thorngren, 2003). Therefore, negative perceptions may exist about mental health services due to a lack of understanding about mental illness or treatment. A recent study (Sirey et al., 2001) indicated stigma not only dissuades people from seeking mental health services, but may also impede progress once people are engaged in the treatment process. Esters, Cooker, and Ittenbach (1998) argued that the effects of this stigma are magnified among rural Americans. As noted by Roberts, Battaglia, & Epstein (1999), “Rural communities have been likened to fish bowls. Comings and goings at the mental health clinic are observed and people listen carefully to comments of clinic staff members” (p. 500).

Thus, even if individuals do not carry their own stigmatized views regarding mental health issues, in a small rural town where rumors “spread like wildfire”, they may be concerned about how others perceive them. In farming/ranching rural communities, there is also often a strong sense of individualism, a “pull yourself up by your bootstraps” mentality where people are self-sufficient and self-reliant, and solve their own problems (Human & Wasem, 1991; SAMSHA, n.d.). Weinert and Long (1987) explored definitions of physical and psychological health among men and women from 13 rural counties in Montana. The study revealed that health was defined "as the ability to work or to be productive in one's role. Ranchers and farmers stated that pain would be tolerated for extended periods so long as it did not interfere (with work)...mental health problems were rarely mentioned... either because they do not define symptoms as a 'mental health' problem or they are reticent to admit to the symptoms" (p. 33). These findings suggest that individuals who could benefit from mental health treatment may have internalized the need to deal with their problems on their own and not seek assistance.

Human and Wasem (1991) delineate “availability, accessibility and acceptability” as important aspects to consider in the provision of mental health to these communities. Availability is determined by the existence of mental health services, especially in rural areas. Accessibility refers to whether individuals can actually receive existing services, including that they can get to and purchase the services (e.g., to travel long distance without the existence of public transportation). Yet another contributor to inaccessibility is a lack of mental health outreach to isolated communities. Acceptability is characterized by services offered in a way that is consistent with the value system of the community. Barriers to acceptability are 1) self-reliance to manage problems, 2) beliefs about the etiology and treatment of a
mental disorder, and 3) stigma and lack of education about mental illness and the mental health profession.

**Challenges for Mental Health Professionals**

Therapists in rural areas face numerous professional difficulties that differ from practitioners in urban settings. Effective training and skills, unique ethical considerations, understanding of rural culture, maintaining continuing education, professional isolation, lack of appropriate referral and consultation sources and resources, and government regulations and restrictions are several of the obstacles well understood by rural mental health professionals. (NARMH, 2000). Wagenfeld, Murray, Mohatt, & DeBruyn (1993) note the crisis regarding financial accessibility and financial crisis due to lack of funding for state and federal mental health initiatives. Funding is consistently being cut for mental health initiatives. These factors significantly enhance the already existing challenges of providing outpatient mental health services for rural Americans.

Regarding professional training and skills, physicians in public hospitals and clinics are the most accessible regarding the provision of mental health care, however, they often do not specialize in mental health care and receive little training in the way of diagnosis and intervention of mental illness (DeLeon, 2000). Also, although mental health professionals are frequently well trained in general practice, few graduate programs specialize in rural mental health provision (Murray & Keller, 1991). Therefore, mental health professionals who move to a rural community may not have an understanding of rural culture, and may experience their own biases toward individuals embracing rural ways, and the dynamics associated with the therapeutic relationship. The U.S. Department of Health and Human Services, (1997) recommends “that the mental health profession encourage innovative training strategies that are explicitly targeted at expanding the competencies required to practice effectively in rural settings.” Further, as DeLeon (2000) notes, rural mental health providers have fewer training opportunities because of their isolation, fewer colleagues with whom to discuss professional issues, and a greater variety of demands on their time than mental health providers in urban settings. According to the U.S. Department of Health and Human Services(1997), “A variety of creative training mechanisms targeted at different components and stages of the educational process are needed; these include both the didactic and experiential ingredients of formal degree programs (i.e., required and elective course work, clinical practica, and internships), advanced (postgraduate) study, and continuing education strategies.” For those already practicing, continuing education and consultation opportunities are critical for mental health professionals in rural communities but are often unavailable locally.

Several authors emphasize interdisciplinary collaboration and cooperation by mental health practitioners (e.g., Beeson, 1998; Wagenfeld, et al., 1994). Such collaboration is suggested for several reasons. First, individuals frequently suffer from multiple problems aside from the presenting mental health issue, for example, physical health and/or substance abuse. Collaboration in rural areas frequently extends to non-mental health care professionals such as clergy, teachers, judges, police officers, and paraprofessionals (Heyman & VandenBos, 1989; Reed 1992) and appropriate care often requires the combined efforts of several professionals, each with expertise in specific areas. Second, such collaboration serves to reduce professional isolation, stress and burnout and thus supports the retention of providers. However, despite the value of collaboration, Wagenfeld, et. al. (1993) suggest that little collaboration and integration of services is typical in the rural United States.

Although collaboration is essential, in rural settings where only one or a few therapists exist, working with clients or issues beyond their level of expertise may be more the norm than the exception. Therefore, therapists are faced with utilizing a generalist approach rather than the specialization in which they were trained. For example, therapists trained to work with individual adults may find themselves conducting couple or family therapy because there are no other options for those clients due
to distance, finances and other barriers. Such use of a generalist approach versus a specialist approach may lead to ethical concerns regarding clinical competency (Weigel & Baker, 2002). However, in the same respect, those practicing mental health care in a rural community benefits from the flexibility associated with utilizing a generalist approach. Such an approach demonstrates an ability to adjust to the specific needs of individuals and the understanding that there are barriers to clients receiving services elsewhere. Therefore, there is a constant search for balance between professional and ethical issues for mental health practitioners in rural areas which is not typical.

Issues surrounding confidentiality are also challenging for mental health practitioners in a rural setting. Weigel and Baker (2002) enumerate the difficulties surrounding confidentiality in their work. Some of those difficulties involve the real or perceived threat to confidentiality. Clients in rural communities often fear being seen while going into or out of mental health services agency or private practitioners’ offices (Sobel, 1984). Those receiving services may also fear breaches of confidentiality amongst mental health employees within a particular agency. Further, due to the nature of small rural communities, therapists likely will see clients at the grocery store, church, social events, etc. Therefore, managing public encounters must be discussed with clients and the nature of confidentiality in these situations understood. Horst (1989) stated that even though the likelihood of non-professional client contact is increased in a rural setting, rural psychologists did not engage with clients in a manner that would “confuse roles” in the therapeutic relationship any more than urban psychologists.

In this article, we explore one community’s attempt to address some of barriers to mental health affecting rural Americans and rural mental health practitioners living in Montana.

A Graduate Training and Community Counseling Clinic

A graduate training clinic was established in 1983 as a component of the Master’s level counseling program at Montana State University (MSU). The clinic is the training site for 25 counseling students per year who are completing their clinical practicum requirements and is an internship site for four pre-master’s level interns and one post-master’s intern. The goals of the clinic are as follows: 1) to provide low-cost mental health services to adults, adolescents, children, couples, and families in southwest Montana; the clinic serves approximately 100 community clients at a time on an ongoing basis; 2) to serve as a training site for the graduate counseling students; 3) to conduct outreach to rural areas; and 4) to provide continuing education and training for licensed counselors and healthcare providers in the region and state. The clinic operates from two locations with a main branch at MSU in Bozeman, a town with a population of approximately 32,000 and a satellite clinic in West Yellowstone, a town with a population of approximately 1200. Both settings are discrete (e.g., off-campus) and allow for client privacy. Master’s level students in the Counseling Program at MSU provide individual, couple, family and group counseling under the supervision of licensed mental health professionals who are faculty at MSU. All sessions with clients are videotaped or audiotaped for the purpose of supervision or sessions are observed “live” by a supervisor and practicum team. The nature of the training component of the clinic is explained, confidentiality is addressed and written consent is obtained for all clients.

As mentioned above, there is a significant problem in rural areas. Limited access to care is a barrier especially for those who are uninsured or under insured (Stamm, 2003). Our first goal addresses this problem of financial inaccessibility of mental health services (NIMH, 2000b). The clinic operates on a sliding fee scale and primarily serves a population who cannot afford insurance, have pre-existing conditions which are not covered by insurance, have insurance which does not cover mental health services, and/or those who do not qualify for Medicaid or other subsidized health care plans. Clients are not refused care due to an inability to pay and fees are often lowered depending on clients’ changing financial needs. The clinic is a non-profit agency supported primarily by client fees and fund-raising. Grants are also being sought to promote additional services. As a component of the MSU Department
of Health and Human Development, the clinic is able to provide services at low cost to the community. Therefore, as many rural communities (including those in Montana) face financial crises and the cutting of mental health initiatives due to lack of state and federal funding, the clinic has been unaffected by such policy changes. It appears that the Clinic's ability to provide mental health services will remain unaffected by changing employment rates and healthcare plan policies because a constant influx of student counselors will continue to staff the Clinic and also student counselors are not yet licensed providers able to accept insurance.

Regarding the second goal of the clinic, the Master's program in Counseling at Montana State University offers three professional tracks, Mental Health, Marriage and Family, and School Counseling (School Counseling does not participate at the clinic and therefore, will not be discussed here). The Mental Health track trains students to counsel individual adults and adolescents. The Marriage and Family program offers students training in individual, couple, family, and child therapy. A rural mental health emphasis is present in all programs. Hovestadt, Fenell and Canfield (2002) outline six characteristics of effective providers of marriage and family therapy (MFT) in rural mental health settings: 1) effective skills in MFT, 2) rural community understanding, appreciation and participation, 3) flexibility (i.e., in tx modalities, acceptance of different types of rural people, cope with out of office unplanned social meetings, being on-call), 4) skills working with a wide variety of problems while still having specialized MFT abilities, 5) education, training and experience in MFT- (i.e., understanding a systems perspective, brief and crisis therapy skills, reduce stigma attached to counseling, confidentiality), and 6) utilization of formal and informal community resources. In fact, both mental health and marriage and family programs emphasize the key points of these criteria with respect to mental health and marriage and family counseling. Formal training, in the form of coursework and practicum, focuses on counseling skills, theoretical orientation, consultation, professional issues, outreach, confidentiality, dual-relationships, ethics, systemic perspective, brief and crisis therapy skills, and understanding rural individuals and communities.

The clinic is the place where coursework is put into action. The clinic is the practicum placement of both mental health and marriage and family counselors for two semesters and an internship site to four advanced students who have completed their practicum requirements and one student who has completed the program and is completing a post-master's internship. The importance of professionalism, ethics, cultural issues, consultation and collaboration is emphasized in training both practicum students and interns. Students learn how to conduct initial intake assessments, exhibit competence in case presentations and case conceptualizations, and provide peer supervision. Ethical and professional dilemmas typical in rural communities (i.e., dual relationships, confidentiality, public encounters with clients) are processed in supervision and students learn to deal with these common issues in a professional and ethical manner. In addition to coursework specifically devoted to the area of consultation, the clinic offers students practice in utilizing these skills in order consult and collaborate with medical professionals, social service agencies, and other community resources. Consultation often includes working with a supervisor to achieve the most effective course of therapy, discussion of client issues with medical professionals, working with social service agencies regarding domestic violence or abuse, and arranging other services for clients (i.e., psychiatric evaluation, nutrition counseling, child care assistance, food bank, housing needs, legal services). Beeson (1998) noted the importance of developing alliances with mental health, general health care and other community agencies and organizations. For the clinic, these alliances are critical for the following reasons: 1) Coordination of services is necessary for clients' care. Individuals problems are often multifarious, including physical health, mental health, financial, and/or substance abuse (e.g., Larson, Beeson, & Mohatt, 1993; Wagenfeld, et al., 1994). Thus, appropriate care may require the combined efforts of professionals from a variety of disciplines. 2) To decrease the professional isolation of student counselors and to teach students to utilize consultation as a necessary protocol for practice, 3) to increase the communities' understanding of the services provided by the clinic and 4) to foster the exchange of referrals between

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the clinic and other services.

To address the third goal, a major part of the efforts of the clinic director and interns are directed toward community outreach. Outreach is conducted in order to educate the community about mental health and mental illness, to decrease stigma regarding mental illness, and to provide service to the community by interfacing with individuals, schools, the legal system, and mental health, healthcare, and social service professionals in order to meet the mental health needs of the community. Some examples of community outreach which the clinic has organized or participated in are: the weekly provision of therapy at local nursing homes, participation in Mental Health Awareness Day which included education about mental illness and available community services for individuals, participation in National Depression Screening Day (provided psychoeducation on mental illness, depression screening and arranged therapy appointments as needed), conducted presentations for staff at local and rural agencies, hospital/medical clinics, the Montana Bar Association, and other organizations regarding clinic services, provided educational information on post-trauma symptoms via radio, television, and newspaper regarding the events of September 11, 2001. Another important component of outreach in rural Montana appears to be flexibility in programming and type of services to meet the changing mental health needs of the community. Within conducting such outreach services, students learn means of extending themselves as counselors to a more difficult to reach population and to address the needs of a rural community.

The fourth goal of the clinic is to provide continuing education for mental health and other healthcare providers in the community. In rural Montana, the scope of available educational opportunities is limited. To partially address this problem, the clinic hosts monthly sack-lunch seminars for mental health professionals where speakers from numerous disciplines (e.g., attorneys, mental health professionals, medical professionals, domestic violence educators) present on issues which have included the topics of: treatment of substance abuse disorders, dealing with domestic violence, attachment disorder, and managing client crises in a rural setting. Continuing Education credits (CEUs) are provided to licensed professionals attending the seminars. Comments from those attending the seminars have all been positive and attendees state they are thankful for an opportunity to receive CEUs. The seminars also have been valuable in expanding students' knowledge of professional issues as well as increasing contact between mental health professionals in southwest Montana. In addition, the clinic hosts a yearly two-day seminar presented by a nationally recognized mental health professional. Professionals receive CEUs and students are encouraged to attend. Other educational opportunities have been provided by clinic staff who have conducted mental health related workshops and seminars with employees from Yellowstone National Park, school counselors, businesses, local agencies and churches. In addition, as opportunities for counseling supervision and means of receiving further clinical training are often difficult to obtain, supervision and/or clinical hours at the clinic are occasionally available for unlicensed professional counselors seeking licensure.

**Limitations and Challenges**

Despite the comprehensive nature of our training program in addressing rural issues, there are several limitations to the training and services provided by the clinic. First, although alcohol and drug addictions are a common problem in rural areas, the Counseling Program offers only one course on alcohol and drug issues. Because the students are not trained in this area, services are not offered through the clinic to address such problems. Chemical dependency is not often the presenting problem of clients and is often minimized as a problem at all. During an intake session, when student counselors or supervisors discern that alcohol or drug use is problematic for an individual seeking therapy at the clinic, continuation of therapy at the clinic, referral for an appropriate level of CD treatment, or a combination of the two are considered on a case-by-case basis. Second, due to the nature of a being training clinic, we are not staffed to offer emergency services. Therefore, we can offer only limited services to clients with severe mental illness such as severe depression, schizophrenia, and bipolar disorder. Because
available and affordable services for this population are sparse, consistent treatment for those with severe mental illness remains very problematic rural Montana.

As well as limitations to our services, there are numerous challenges the counselors face as rural mental health providers. One challenge that student counselors face often is knowing clients who are being seen by other student counselors. In order to maintain client confidentiality and to avoid dual relationships, student counselors remove themselves from any consultation or knowledge regarding that client’s counseling. Another related challenge is that students often see clients who are indirectly a part of their peer group. For example, a student may see a client who is a friend-of-a-friend but not initially be aware of this fact. Due to the nature of working in a rural community, such practices are more common than not, and not easily avoided. This issue is commonly addressed as a part of supervision. A third challenge is that although the clinic has attempted to start numerous therapeutic groups, getting a sufficient number of individuals to partake at all or on a consistent basis is difficult. Clinic staff speculate that such lack of interest is due to difficulties associate with low-income status (working two jobs, more pressing stressors than the one being addressed by the group, childcare) and rural status (travel distance, value of self-reliance) as well as other reasons. Therefore, for students, gaining experience as a group therapy facilitator is difficult to obtain.

The Future of Rural Mental Health

Although the training clinic at MSU fills a gap in rural mental health in several critical areas for southeastern Montana, this type of clinic is by no means a solution to all of the complex issues surrounding the mental health needs of rural communities. Research should further address the specific needs of rural communities, barriers to receiving mental health services, and means of decreasing stigma and increasing understanding of mental illness for rural individuals. Also, the provision of appropriate training and opportunities for continuing education to rural mental health professionals should continue to be addressed.

REFERENCES


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