

The RURAL MONITOR

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The Stigma of Mental Illness

By Thomas D. Rowley

Mental illness is a difficult subject for most people to handle—it is, in a word, stigmatized.

Despite the fact that one out of every five Americans experiences some type of mental disorder in any given year, and one out of two is affected at some time in his or her life, mental illness continues to be wrapped in misconceptions, myths and cultural taboos.

The stigma of mental illness leads to a host of additional problems—some nearly as bad as the disease itself.

Unfortunately, that stigma has not diminished in recent years. Oscar Morgan, Chief Operating Officer of the National Mental Health Association, describes what happened a couple of years ago to a prominent man in a small southern town who suffered from depression. With proper medical attention, he had been able to keep it in check and go on about his business. Indeed, he was active in civic groups and served on the city council. Then his doctor died.

Since no one other than family knew of his illness, the man was uncomfortable going to another caregiver. His condition deteriorated. When he finally sought help at the local emergency room, doctors there dismissed his symptoms as nothing to worry about. After all, they reckoned, here was a pillar of the community and a highly functioning individual. How could he have a mental illness? His condition grew still worse and the man became suicidal. His wife had no choice but to call 911. The paramedics and police took him away—

in front of friends, neighbors and colleagues.

Even more humiliating, out of confusion and fear over what his illness meant for the man's abilities, a civic group on which he served removed him from its board. According to Morgan, that more than anything else hurt the man and his family. It also confirmed their initial hesitation in not telling anyone.

"All his years as a pillar of the community went out the door," Morgan says.

The story illustrates in painfully stark terms the many facets of stigma: inadequate knowledge about mental illness, even in the medical profession; fear of and prejudice toward those with mental illness; and a hesitancy on the part of people with mental illness to get treatment. According to Ann Kirkwood, Senior Research Associate at Idaho State University's Institute of Rural Health, stigma is the number one barrier to treatment seeking by people with mental disorders. That, combined with other factors, keeps one half of the 44 million people in the United States with mental illness from getting help.

Morgan's story also illustrates another important thing about stigma: it is often worse in rural areas.

Compounding Rural Factors

While the romantic stereotype of rural life may be one of carefree days in the peaceful countryside, the reality is often quite different. Economic difficulties,

(continued on next page)

geographic isolation and a lack of critical services can make rural life anything but carefree. As a result, studies show that rural dwellers have rates of mental illness equal to or higher than city folks. In addition, rural areas have higher proportions of elderly and chronically ill—people more at risk for mental illness. On top of all that, many rural areas have several other characteristics that complicate matters and compound the problem.

“In our rural areas in the West, we have what I call the ‘cowboy-up’ culture,” Kirkwood says, referring to the pick-yourself-up, dust-yourself-off and get-on-with-it attitude prevalent in many rural areas. “It is deeply embedded in our culture that you take care of yourself.”

According to Kirkwood and other experts on the subject, that culture—however meritorious or admirable in terms of resilience and personal responsibility—can cause great damage when it comes to mental illness.

It is, also, quite understandable.

Because of their small size and close-knit social fabrics, rural communities are known for knowing everybody and everybody’s business.

“In Alaska,” Kirkwood says, “they call it the ‘mukluk telegraph.’ Information flies out into the community.”

In other communities she has seen, the mental health office sits across from the local coffee shop or by itself on Main Street with no place to park but right in front, where everyone can see your car.

When it comes to seeking mental health treatment, such familiarity can prove a hindrance.

Another hindrance comes from a lack of mental health care providers and services in rural areas. According to rural health researchers at Texas A&M University’s Southwest Rural Health Research Center, 20 percent of

nonmetropolitan counties (versus five percent of metropolitan counties) lack mental health services; and in 1999, 87 percent of the 1,669 federally designated Mental Health Professional Shortage Areas in the nation were in nonmetropolitan counties.

Due in part to this lack of mental health providers (and also to the fact that even in communities with mental health providers, people are more apt to see their regular physician for mental health issues), primary care doctors provide the majority of mental health services in rural areas, as much as 60-70 percent according to some estimates.

And while some care is arguably better than no care, primary care physicians and providers are not always fully prepared to deal with mental health issues.

“Is a primary care doctor in a rural community really equipped to treat the illness in the way it needs to be treated?” Morgan asks. “What resources do they have?”

On top of that, some research shows that primary care physicians may deliberately underdiagnose mental illness because of a reluctance to expose the patient to stigma, doubts about the patient’s acceptance of a mental disorder diagnosis or a concern for the patient’s future insurability.

The list of missing services does not end with appropriate medical care. Critical support services like transportation, housing and vocational training are also typically in short supply in rural areas, all making it difficult for people to get the help they need.

Finally, public education about and familiarity with mental illness play a key role in whether mental illness and those with it will be stigmatized or accepted in a community. Here again, rural areas often come up short due to lack of exposure to the subject and lack of services that could increase their

familiarity with it. All of which can be made worse when combined with the “cowboy-up” culture.

“People do not understand what mental disorders are,” says Kirkwood, who has bi-polar disorder. “It’s not an issue of weak character or moral problems.”

Not surprisingly, absent better information, people often rely on what they see on television and in the movies. Kirkwood cites a study showing that people get their information about mental health from the mass media 65 percent of the time.

“That’s very negative,” she says. “Movies, television, the media cover the sensational. That begins to develop into a component of fear. Most people with mental illness are your neighbors, your friends, your coworkers. If they don’t tell you about it, the only place you get it is the media.”

As a result of all these compounding factors, research shows that utilization of mental health services is lower in rural than in urban areas.

On the Other Hand

While small, close-knit rural areas face a tough row to hoe when it comes to providing mental health care, they offer what larger communities often cannot: small community support.

“The advantage of a small town is that we have the ability to take care of each other. There’s great power in that if we can tap it for mental illness,” says Kirkwood.

Christina Lymberopoulos has seen that advantage first hand, even while battling against the disadvantages.

Her 14-year-old son, Matthew McIntosh, started having problems at age one and a half, when he would stay awake for days on end and at times fly into uncontrollable rages. At age five, he started taking medication.



Christina Lymberopoulos with her 14-year-old son, Matthew McIntosh.

“They didn’t really tell me what was wrong,” Lymberopoulos says. “They just said he was a little hyper.”

That all changed one day when Matt came to her and said he couldn’t make the voices in his head stop. When she asked him what the voices were saying, he replied, “Blow up the mailbox.” It was a rude awakening.

Since then, Matt has been diagnosed with bi-polar disorder, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder and oppositional defiant disorder. (The last, she describes like this: “If you told Matt to breathe, he’d stop.”)

He also has been hospitalized six times, has had some run-ins with the law and is now in residential treatment in Lewiston, Idaho, an hour away from their home in Orofino. There is a state mental hospital in Orofino, but it does not accept children.

Obviously, living in a rural area makes it difficult to get all the services Matt needs. And having him so far away makes it extremely tough to stay connected. On the other hand, Lymberopoulos describes her town of

3,000 as “our own little acre of heaven.” She says it offers her the familiarity and community support that she wouldn’t be able to find in the city.

In search of that small town atmosphere she, Matt, and Matt’s father (now deceased) moved there when Matt was still a small child. The doctors treating Matt’s father, who had been ill for some time, told them he needed to go where it was “quieter and slower” and Matt’s neurologist said Matt “would not do so well in the city.”

“I knew just the place,” says Lymberopoulos, whose stepfather had grown up near Orofino.

“When you’re in the city, if you educate someone about your needs, six months later they’re not there. Here, people know me and my son. They see the truths that people in the city don’t—that I’m an attentive parent, that Matt is a productive member of society. In the big city, people don’t always get to see that. These people are very involved in their community. This is their home. This is their place.”

As evidence of that support, Lymberopoulos cites the teachers who have gone out of their way to learn about Matt’s illness and help him and the sheriff’s deputies who are aware of his problems and look out for him.

Overcoming Stigma

None of which is to say that it’s all been easy. Lymberopoulos tells of having a school principal look her in the eye and tell her that there was nothing wrong with her son. (After later seeing Matt have a psychotic episode, the principal apologized profusely and became a great supporter). Over the years, she has heard critical comments from some of the townspeople. . . She recounts some of them.

“Did you do drugs when you were pregnant?” To which, she answers, “Yes, prenatal vitamins.”

“Did you drink?” Her response: “Yeah, about a half-gallon of milk a day.”

Matt’s responses, however, are the best, she says.

When someone referred to a mental hospital as “the hotel silly,” Matt replied, “I don’t know why you call it that, because when you’re there you don’t feel silly.”

Or when people talk about someone being mental, Matt will say, “I’m mental and that’s not what it’s like.”

Still, Lymberopoulos is firm in her appreciation for her community. And, she adds, things are getting better—due in no small part to her and her son’s own efforts.

Research shows that the most effective way to reduce stigma is through personal contact with someone with a mental illness. Lymberopoulos and her son exemplify that. Because they are open and upfront about Matt’s illness, people see that someone with mental illness can be an intelligent and active member of his community. (Matt’s IQ is 120, he is on the honor roll and he helps out at the local firehouse cleaning hoses and cooking breakfast at fundraisers.)

The two have also made presentations to the Idaho State Mental Health Planning Council and the state legislature, helping them understand what mental illness is like and what people with mental illness are capable of.

Finally, Lymberopoulos volunteers with the local children’s mental health council, which screens children for illness and then helps get the child and his/her parents the resources they need to deal with it.

Through all their efforts, mother and son try to put a personal face on the disease in order to educate people and help them see mental illness for what it really is—not a character flaw or moral weakness, or something to be discussed

in hushed tones, but a disease like any other, one that affects vast numbers of people and that can be effectively treated. It takes a willingness to speak up.

“If you see something that needs to be changed, change it,” Lymberopoulos

says. “There’s no reason why anyone with a mental illness shouldn’t be looked on as someone with something to contribute. If we turn our backs on people with mental illness, we’d be turning our backs on some of the greatest people in society.”

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at: editor@raconline.org

FACTS ON MENTAL ILLNESS

For many, the stigma associated with mental illness stems from ignorance about exactly what mental illness is. According to the report, *Mental Health and Mental Disorders: A Rural Challenge* by researchers at Texas A&M University’s Southwest Rural Health Research Center, mental illness refers collectively to all diagnosable mental disorders. Disorders, in turn, are health conditions characterized by alterations in thinking, mood and/or behavior, which are associated with distress and/or impaired functioning and cause problems including disability, pain or death.

There are three major categories of mental disorders: schizophrenia (which affects more than two million Americans per year); affective disorders, such as major depression and manic depressive illness (which are the leading cause of disability among adults in developed nations and are associated with high rates of suicide); and anxiety disorders, such as panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder and phobia (which are more common than other mental disorders and affect as many as 19 million Americans each year).

As with other major diseases, the personal and economic costs of mental illness are enormous.

- According to the World Health Organization, worldwide, mental illnesses account for five of the 10 leading causes of disability.

- According to The President’s New Freedom Commission on Mental Health, mental illnesses rank first among illnesses that cause disability in the United States, Canada and Western Europe.

- The Commission also reports that in addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the United States, the annual economic, indirect cost of mental illnesses is estimated at \$79 billion. Of that \$79 billion, \$63 billion is from the loss of productivity due to illness, \$12 billion is from lost productivity due to premature death, \$4 billion is from productivity losses for incarcerated individuals and for the time of those who provide family care.

- According to the National Mental Health Association, untreated and mistreated mental illnesses cost the United States another \$150 billion in lost productivity and \$8 billion in crime and welfare expenditures each year.

According to the Texas A&M study, the toll from mental illness is no less significant in rural areas.

- State and local rural health leaders rank mental health and mental disorders as the fourth highest rural health priority, behind access, oral health and diabetes.

- The impact of mental health and mental disorders on mortality in rural

areas appears in several forms. Suicide rates, a standard indicator of mental illness, are higher in rural areas, particularly among adult males and children. More suicide attempts, too, occur among depressed adults in rural areas than in urban areas.

And yet, mental illness is treatable. Indeed, according to the National Mental Health Association, treatment success rates for mental disorders such as depression (80 percent), panic disorder (70-90 percent) and schizophrenia (60 percent), surpass those of other medical conditions such as heart disease (45-50 percent).

Despite these success rates, many people think mental illness is a permanent, untreatable disability. In addition, many are mistaken about the effects of mental illness. For example, according to the President’s Commission, 61 percent of Americans think that people with schizophrenia are likely to be dangerous to others, when in reality they rarely are violent. If they are violent, the violence is often tied to substance abuse.

Which goes to show the critical need for public education about mental illness. In his charge to the New Freedom Commission on Mental Health, President Bush said, “Americans must understand and send this message: mental disability is not a scandal—it is an illness. And like physical illness, it is treatable, especially when the treatment comes early.”

RESOURCES

Efforts are underway around the country to reduce the stigma of mental illness. Some have a rural focus; others do not, but offer resources appropriate to rural areas just the same. Below is a small sample of offerings:

- Better Today's. Better Tomorrow's. This project of Idaho State University's Institute of Rural Health and other partners educates gatekeepers and caregivers on the signs and symptoms of mental disorders in children and youth. Since its inception four years ago, the project has trained approximately 1,500 professionals, parents and community members statewide.
<http://www.isu.edu/irh/bettertoday's/>
- *The 2004 Report to the Secretary: Rural Health and Human Service Issues* by the National Advisory Committee on Rural Health and Human Services examines the issues surrounding integration of mental health services with primary care services in rural areas and offers policy recommendations to better achieve it.
<http://ruralcommittee.hrsa.gov/March2004nacltr.htm>
- The National Mental Health Association and its 340 affiliates nationwide offer a wide array of resources on all aspects of mental health and mental illness.
<http://www.nmha.org/>
- The National Association for Rural Mental Health works to develop and enhance rural mental health and substance abuse services and to support mental health providers in rural areas.
<http://narmh.org/>
- The President's New Freedom Commission on Mental Health studies the problems in the current mental health service delivery system that allow Americans to fall through the system's cracks and recommends actions that the federal government, state governments, local agencies, as well as public and private health care providers, can implement to address those problems.
<http://www.mentalhealthcommission.gov/>
- The Rural Healthy People 2010 Project is a research effort aimed at identifying and addressing the priority health concerns of rural America, including mental health. For each rural health priority identified, the project provides a brief review of literature and summaries of illustrative solutions.
<http://www.srph.tamushsc.edu/centers/rhp2010/>
- The National Mental Health Information Center at the U.S. Department of Health and Human Services provides an enormous array of information about programs, services and resources in mental health and mental illness.
<http://www.mentalhealth.samhsa.gov/>
- The American Association for Marriage and Family Therapy maintains a web site search engine that allows users to find counselors by zip code.
<http://www.therapistlocator.net/>
- The Rural Assistance Center (RAC) Mental Health Information Guide focuses on rural mental health issues and topics. The guide includes relevant information pulled from news, funding and events sections of the RAC web site, as well as links to useful publications, mental health organizations and other helpful web sites. Additional in-depth information is found in the Frequently Asked Questions (FAQs), the Terms & Acronyms and the Contacts sections.
http://www.raconline.org/info_guides/mental_health/
- The U.S. Department of Health and Human Services also maintains a toll-free crisis hotline at 1-800-273-8255.



Rethinking Human Services

by Tom Corbett, Ph.D.

Why is Integrating Human Services so Difficult?

The need for better systems of service delivery in rural areas is apparent. Of the 50 counties in the United States with the highest child poverty rates, 48 are rural. Fully one rural child in four lives with a single parent and one rural child in three lives in a family where no parent has full-time, year-round employment. In short, rural families with children fare no better than their urban counterparts; in some ways, they may face even more daunting prospects.

One possible solution, I have argued in prior articles, is to develop collaborative strategies for delivering human services which many call integrated service models, a vision for delivering comprehensive human services that blend together separate programs and systems in imaginative ways.

At the same time, there are some daunting challenges faced by human service systems located in rural communities. Virginia, for example, developed a set of pilot initiatives covering four rural communities called Coordinated Economic Relief Centers (CERCs). They were designed to support workers and their families and provide the services of many agencies at a one-stop location.

Evaluators from Mathematica Policy Research (MPR) determined that, on the whole, the CERC pilot programs did not live up to their promise of providing better and more accessible services to low-income families facing challenges in today's rural labor market. MPR evaluators cited resource constraints, limited planning and development time, inadequate record keeping and unrealistic expectations as the major reasons these pilots did not do better.

Unfortunately, the Virginia experience is not the exception. Many com-

munities around the country have experimented with integrated service models. Surprisingly few have endured or succeeded in transforming the way we help challenged families.

One researcher, Jodi Sandfort, followed attempts in Michigan to integrate functions separately carried out by the welfare and workforce development systems. Sandfort writes that these integrated service models are, by their very nature, complex and that "the 'core technologies' of such human service innovations cannot be easily standardized." Thus, the ongoing challenges faced by these collaborative initiatives demand that primary tasks and activities be "negotiated afresh in the daily interactions between front line workers and clients." She ultimately concludes that "managers will be able to accomplish better, more integrated service delivery only by understanding how to shape the deeper structures in human service organizations that determine or constrain action."¹

What does all that mean? It means that advocates for one-stop service centers and other forms of integrated service models cannot assume that simply putting separate programs in the same building, or providing some cross-training and other supports, will result in true integration. To achieve that end, planners and managers must fully appreciate the underlying culture of each program being blended together.

And what is this nebulous thing called "institutional culture"? Basically, it is a shorthand term that captures the underlying norms, values and behavioral patterns that shape the way an agency (or organization) functions and makes decisions. It is the whole set of sometimes unconscious guides that inform how organizational members think, act and relate to one another.

One correlate of an institution's culture is its "core technology," the central tasks it performs. For example,

does a program (or agency) primarily issue benefits (e.g., a welfare program), deliver complex services in a relatively routine fashion (e.g., many work attachment programs) or intervene in highly dysfunctional families to remedy problems and transform behaviors (e.g., domestic violence or substance abuse programs). These fundamentally distinct kinds of tasks—fully routinized, partially routinized and nonroutinized systems—shape different types of organizational cultures.

Benefits-issuing programs such as Food Stamps or housing subsidies typically involve repeated and routine tasks performed within a strict regulatory environment. Not surprisingly, the dominant culture in such programs is a top-down management style and conformity to written rules.

At the other extreme, intervention or crisis-oriented service programs thrive in organizational cultures that deviate radically from true bureaucratic forms. Each interaction between system and client is likely to be unique, or at least have some elements of unpredictability. Professional judgment, not slavish rule conformity, is prized. In such systems, one might expect to see what we call flat hierarchies (few management levels), decentralized decision-making processes (front-line participation) and incentive structures that encourage innovation and flexibility.

Putting together programs from similar organizational cultures, although still difficult, is less daunting than blending programs or agencies drawn from different cultures. Just think about the problems that may arise when welfare workers who seldom, if ever, exercise discretion are now required to work closely with social workers who regularly exercise professional judgment. The prospects for misunderstanding, miscommunication, mistrust and acrimony are all too apparent.

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Look What's Coming

by Wayne Myers, M.D.

2011: Meltdown and Recasting

Health care bills are a factor in about half of household bankruptcies, which are at an all-time high. At this writing Congress is focused on controlling bankruptcy instead of its causes. Eventually the problem of health costs will have to be dealt with. Health costs have been taking increasingly large bites of our economy for 75 years and won't stop without major structural change. To gather material for this column I cashed in a bunch of frequent flyer miles and made a trip to the year 2011. This is what I learned.

Early on, the spiral toward meltdown was subtle and without a clear beginning. Since the early 1990s families' health costs had been continually shifting from employers to employees as unaffordable premiums, deductibles and co-pays. More recently, federal cuts to the Medicaid budget were interacting with states' budget difficulties to produce Medicaid enrollment cuts. The proportion of the population with real insurance was dwindling.

The health care meltdown began heating up in 2006. Hospitals and clinics were seeing their bad debt and accounts receivable climb. They shifted ever more costs to insured and paying customers making insurance even less affordable, increasing the percentage of uninsured and accelerating the spiral. More and more providers became unable to pay suppliers, to make payroll or to keep their doors open. The first to go under were those with the largest share of indigent patients. Their demise shifted the indigent care load to more affluent hospitals. People getting into hospitals were sicker and the number of preventable deaths climbed.

At first political economists spun the phenomenon as a necessary shake-out of redundant capacity. This interpretation had some early adherents since the bulk of early failures were in poorer commu-

nities. But within months even flagship institutions were in trouble.

Health care dominated the run-up to the 2008 election. In early 2007 about 17 percent of working Americans had jobs in health care. By Election Day a quarter of the hospitals and clinics had closed and a quarter of these workers were out of work with no prospect of finding another health job. Any surplus capacity in health care was long gone. People couldn't find care. Investors holding hospitals bonds were screaming.

The administration was paralyzed. There were two key arguments. First, is health care a right or a purchasable service—i.e., should hospitals and clinics have to care for people who can't pay? Second, should essential services be preserved by government action or should the market handle the issue? The administration stayed the market course.

The fact that it was an election year hurt and helped. It thwarted prompt action, but it also exposed the issues to brutal public debate and extracted very public commitments from candidates. Special interests often collided and were neutralized. The new administration took office with a mandate to stabilize the situation. In its "first hundred days" it laid out a plan to buy selected hospitals for their indebtedness. Except in a few remote rural areas, failing private clinics were permitted to go under. There were just too many to deal with. Instead, hospital-based clinics and community health centers were expanded, hiring docs from the private sector. There was no question about the need to manage this federal hodge-podge. Legislation was passed permitting the feds to negotiate with vendors of essential drugs, goods and services. The Veterans Administration hospital personnel management and patient care protocols were applied in the founding institutions as were various

longstanding recommendations for safer, more equal care. Consolidation of management and billing structures, plus direct federal payment, saved some money as did bulk negotiated purchasing and other economies of scale. Overall savings approached 20 percent, but hundreds of thousands of fiscal and billing personnel lost their jobs.

The switch-over was paid for by a broad employer-employee payroll tax which replaced insurance payments. The indigent care piece was covered by a wealth tax on individuals with net worth of over \$5 million.

There were unanticipated consequences. There was a surge in development when people with ideas for small businesses could count on affordable health care. The competitive advantage of "big box" retailers decreased when they had to help pay for employee health care through the health payroll tax. The small service companies thought they couldn't afford the health payroll tax, but since all their competitors were in the same boat most survived.

By 2011 America had two tiers of health care. The wealthy continued to use boutique providers who continued to do very well. Over half of all hospitals continued in private ownership receiving federal payment through a Medicare sort of scheme. But for many Americans the federal health program was their health care home. It was "big government," clumsy and imperfect, but fair and affordable.

In future columns, I hope to fill in more details on the program and how it evolved.

Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.

Around the Country

by Thomas D. Rowley

Alabama

Horses Helping People Heal

Serendipity Therapeutic Horse Farm, 11 acres on the outskirts of Tuscaloosa, is home to goats, pigs, chickens, ducks, dogs, cats, and, of course, horses. It is also home to four equine assisted therapy and recreation programs.

More so than any other animal, horses seem to have the ability to help people heal—whether physically or psychologically, says Dr. Marguerite Malone, a clinical psychologist and adjunct professor at the University of Alabama. Malone and her husband, Forrest R. Scogin, Jr., a professor of Psychology at the University of Alabama, own and operate the farm.

In physical therapy, the use of horses helps strengthen a patient's muscles while also helping the patient's coordination and "muscle firing mechanisms." Malone says several patients have learned to walk through equine therapy.

In psychotherapy, horses work on several levels, according to Malone.

"People in psychotherapy often are having a hard time connecting with other people," Malone says. "They can connect with the horse. The horse doesn't have a lot of baggage. The horse reacts to the people without filtering it through the social behaviors that other people do. The horse provides a wonderful mirror for people trying to figure those things out."

As for the effectiveness of equine assisted psychotherapy, Malone says they can get six to eight weeks worth of work done in one session of group activities.

In all cases, Malone says, the horses help build self-confidence in patients as they work with an animal 10 times their size and get it to do what they ask of it. Plus, the horses just make people feel good. "You just feel some emotional, sense of warmth, acceptance, and love

from a horse than anything else," Malone says.

There are four programs at Serendipity Farms:

- Bama Equine Assisted Therapies, Inc. uses horses to help provide clients with speech, occupational and physical therapy. The program also trains students in the Speech and Communication Department at the University to perform equine assisted speech therapy, which has the patient give commands to the horse and also engage in language exercises while riding. It is directed by Beth Macauley, a speech therapist who is on the faculty at the University's Department of Communication Disorders.

- Evermore Equine Facilitated Psychotherapy provides individual, group and family psychotherapy to adults and children in the West Alabama area. The program also provides research opportunities into the efficacy of horse assisted/facilitated therapy for doctoral students at the University's Departments of Psychology and Social Work. It is directed by Malone.

- The Miracle Riders Program of the United Cerebral Palsy (UCP) of West Alabama provides recreational riding opportunities for people with physical challenges. While not therapy per se, the program uses a physical therapist to help riders benefit in ways beyond the mere fun of riding.

- Therapeutic Riding of Tuscaloosa (TROT) is a new program that will provide ongoing horse-related activities to disabled individuals who do not need therapy but still want to continue their contact with horses. The main thrust of this program is to integrate physically



Participants at the Serendipity Therapeutic Horse Farm, located on 11 acres on the outskirts of Tuscaloosa, Alabama.

and mentally challenged riders with non-disabled peers in an effort to promote appreciation of diversity and facilitate the interactions of these two groups in a recreational setting. It is being coordinated by Malone, UCP of West Alabama and the Alabama Division of Rehabilitation Services.

In addition to hosting the four programs, Serendipity Farm is also involved in a program to breed better therapy horses. The program, Malone says, is showing great promise.

For more information, see <http://www.therapyhorses.us/> or contact Margo Malone at margo@therapyhorses.us.

Arkansas

A Unique Partnership

Arkansas' Corning Area Healthcare, Inc. has teamed up with Lawrence Health Services in the nation's first partnership between a Federally Qualified Health Center (FQHC) and Critical Access Hospital (CAH).

Individually, the partners serve underserved and uninsured people in the state's northeast corner—part of the Mississippi Delta. Together, they can provide that service more efficiently and effectively.

Bill Rodgers, Director of the Arkansas State Office of Rural Health and

Primary Care, says the partnership made sense. “If we’re going to look at systems of care in rural areas, we need to look at partnerships. We want to keep the rural hospital viable. We also want to treat the underserved population. This seemed to be a way that it would work.”

In a nutshell, the partnership enabled the creation of an FQHC site in existing and equipped space at the hospital in Walnut Ridge. It also allowed the hospital to use two of the FQHC’s physicians to staff the Emergency Room during FQHC hours (where many non-emergency patients end up seeking primary care.) Among its many benefits are:

- cost savings from the co-location of facilities and the shared use of physicians;
- enhanced reimbursements due to FQHC eligibility;
- reduction in the use of emergency room by people seeking non-emergency primary care;
- improved quality and continuity of care by increasing access to services; and
- opportunities for joint training, administration, and accreditation.

“We just felt like this would be a great collaboration,” says Corning Executive Director Brigitte McDonald. “There are so many benefits. I could just go on and on and on. Basically it’s just a better way to serve the community. We’re increasing the quality of care.”

Only weeks old, the partnership is already seeing high demand for its services. Leah Osbahr, President of Lawrence Health Services, says that people were calling to sign up for appointments before the doors opened—some from several hours away.

The partnership is part of the Federal Office of Rural Health Policy’s Federally Qualified Health Center/Critical Access Hospital Collaborative, and was nurtured by technical assistance from the State Office of Rural Health and

Primary Care and a Community Health Center expansion grant from the Health Resources and Services Administration’s Bureau of Primary Health Care.

For more information, contact Bill Rodgers at (501) 280-4563 or wrodgers@healthyarkansas.com; contact Brigitte McDonald at brigmcdonald@yahoo.com

For further reading on CHC/Hospital collaboration, the National Rural Health Association recently released “Collaboration: Model Relationships Between Rural Community Health Centers and Hospitals.” This report outlines practical ways that health care providers can collaborate—in areas ranging from workforce recruitment and training, to shared information and communication technology, to shared clinical and administrative staff, to joint community health education and outreach. The report shows that collaboration can improve the quality of health care in a community while having a positive impact on the bottom line. The five model collaborations were developed in rural communities. The report is available at: <http://www.NRHArural.org/quality/collaboration.pdf>. To order print copies of the report, e-mail a request to pubs@NRHArural.org

Missouri

New Center Examines Health Care Disparities

In another partnership, the University of Missouri (MU) Center for Health Policy and Washington University (WU) in St. Louis have teamed up to develop a center that will focus on racial and ethnic health care disparities within the state’s rural and urban areas.

Each of the institutions brings its own unique research perspective to the partnership. While MU has been serving the needs of rural Missourians, WU has been dedicated to providing patient care and studying approaches to

enhancing the health of urban populations.

The collaboration, which has been up and running since the first of the year, is engaged in several research, outreach and training projects including:

- conducting an inventory of relevant research and service and educational programs within the state;
- building a network of professionals, academics and policymakers to focus on the issues; and
- developing specific research, outreach and training exercises to help fill the gaps identified by the inventory—such efforts might include increasing the representation of racial and ethnic minorities in schools of medicine, and working with churches and synagogues to reach medically underserved populations.

According to Kristofer Hagglund, Ph.D., Co-director of the Center for Health Policy at MU, the partnership’s combined rural and urban focus will allow comparisons of similarities and differences across regions and allow the two universities and their surrounding communities to learn from each other. Initial data collection will concentrate on urban St. Louis and the rural Bootheel region of the state.

“This is a complex set of issues and one that’s going to take a truly comprehensive approach to address,” Hagglund says. “It’s also going to take strong partnerships between a lot of people and organizations. The purpose of our collaboration is to share ideas, resources and strategies for implementing high quality health care to racial and ethnic minorities and other underserved populations.”

The project is funded in full by the Missouri Foundation for Health.

For information, see http://www.muhhealth.org/news/www/2005/MU_WU_study05.shtml, or call (573) 882-4141.

Spotlight on Rural Research

by Thomas D. Rowley

The Importance of Rural Schools

More than twice as many rural Americans have college degrees than those from a generation ago—in 2000 nearly one in six rural adults had a four-year college degree. As encouraging as that is, however, educational levels in the countryside still fall below those found in city. And while that lag undoubtedly hurts rural America's communities and economies, the level of pain is not easily quantified nor particularly well-understood.

With the publication of a new report, experts in rural education and rural development have begun filling that knowledge gap.

In Spring 2003, the U.S. Department of Agriculture's Economic Research Service, the Southern Rural Development Center and the Rural School and Community Trust hosted a conference to examine the connections between rural education and community well-being. *The Role of Education: Promoting the Economic and Social Vitality of Rural America* contains nine of the research articles that were presented at the two-day symposium.

In their Introduction, editors Lionel Beaulieu and Robert Gibbs highlight some of the need for the report.

"Today's rural leaders are becoming increasingly attuned to the fact that high achieving schools and related human capital investment strategies are key ingredients in the promotion of sustainable development at the local level. But, serious challenges often await rural areas that seek to pursue such efforts. As a case in point, if rural schools are successful in producing well-educated students, they run the risk of accelerating the exodus of talented youth to the larger cities that offer higher salaries and other important

amenities. Certainly, rural areas can attempt to retain these talented individuals by expanding the availability of better paying, higher quality jobs in the locality. But, in far too many rural places, the necessary infrastructure and fiscal resources needed to create or attract such jobs are simply limited."

In short, everyone knows that a good education is important. What we don't know is just how important, nor whether that importance outweighs the risks of losing the kids we educate—the dreaded brain drain. This report goes a long way toward supplying the answers.

In their chapter Stephan Goetz and Anil Rupasingha of Pennsylvania State University examine the economic returns to education in rural America. They note that a one-percentage point increase in the share of high school graduates raises per capita income by \$128 in a typical rural county. Sadly, but not surprisingly, that same one-point increase in an urban county raises per capita income by \$413.

Why so much higher?

Synergy. Not only does education on its own tend to raise per capita income, it also interacts with other factors, which on their own raise per capita income. Put them together and the resulting synergy among the factors means that the whole is greater than the sum of its parts—more so in urban areas.

For example, an increase in education in an urban area interacts with greater access to interstate highways, higher levels of social capital, more private sector jobs, higher population density and greater amenities to produce a bigger impact on per capita income. In rural areas, the interaction does not always take place (population density, social capital, classroom size and highway access have no statistically

significant leveraging effect on income like they do in urban areas), and the interaction with other variables (private sector jobs, amenities and high-tech establishments) that does take place yields smaller increases in rural income.

Goetz and Rupasingha sum up the problem this way: "Rural counties, therefore, suffer in two ways. First, they have lower population densities to begin with, and second, they would not benefit if they could somehow increase population density." All of which gives "some indication of the staggering odds or disadvantages that rural areas face in terms of providing those with a high school degree a reasonable return on their investment."

In their contribution, David Barkley, Mark Henry, and Haizhen Li of Clemson University state that their findings "reinforce the conventional wisdom that educated labor is critical to future economic development in both urban and rural areas." They cite several ways that human capital contributes to local economic development. It:

- enhances the ability of business to adopt superior technologies and respond to changing economic conditions;
- improves a community's chances of attracting new business, particularly high-skilled, high-wage business; and
- benefits entrepreneurial activity.

In short, "improvements in the educational attainment of the local labor force create numerous opportunities for future community development. It is not clear, however, which types of communities can best take advantage of these opportunities, or how the community development impacts will be realized in terms of income, employment, and population change."

What is clear is that rural areas benefit less. Specifically, the authors find that while county growth rates in per capita income and employment are improved by increases in human capital, the improvements are greater in urban areas than in rural. For example, a five percentage point increase in the share of adults attending college resulted, on average, in:

- a 3.5 percent increase in the growth rate of per capita income in nonmetro areas and a 9.0 percent increase in the growth rate in the metro counties; and
- a 5.5 percent increase in the growth rate of employment in nonmetro areas and a 6.8 percent increase in metro.

Finally, in a chapter on the importance of schools to rural community viability, Thomas Lyson of Cornell University writes that,

“Of all civic institutions in a village, however, the school serves the broadest constituency. Not only do

schools meet the educational needs of a community and may be a source of employment for village residents, the local school also provides social, cultural, and recreational opportunities. It is a place where generations come together and where community identity is forged.”

He backs this claim up with research showing that rural New York villages with schools are more likely than those without schools to:

- grow in population;
- have higher housing values;
- have better physical infrastructure; and
- have proportionally more college graduates and workers in professional occupations.

All of which speaks—and speaks loudly—against consolidation of small schools. Indeed, Lyson writes, “The money that might be saved through consolidation could be forfeited in lost taxes, declining property values and lost businesses.”

Other chapters in this remarkable little volume look at such things as the various factors influencing educational performance, the economic multiplier effect of jobs in the educational sector and how rural schools fare under testing regimes.

For readers wanting to know more about how rural education measures up in general, USDA’s Economic Research Service provides a comprehensive yet pleasingly concise overview in *Rural Education at a Glance*. This brochure-type publication, with easy-to-read maps and charts, is one in the “at a glance” series that provides up-to-date summaries of various facets of rural life.

The Role of Education: Promoting the Economic and Social Vitality of Rural America is available at: <http://srcd.msstate.edu/publications/ruraleducation.pdf>

Rural Education at a Glance is available at: <http://ers.usda.gov/publications/rdr98/>

(Corbett, *continued from page 6*)

In effect, service integration is more than locating different programs in the same building; more than changing a few protocols; more than increased cross-system training; more than updating automated case management systems; and so forth. Successfully achieving service integration demands that we truly understand the culture of each system to be blended. What we do to transform discrepancies and friction across the cultures of candidate systems will be addressed in future articles.

Endnotes

- ¹ See J. Sandfort, “Why Is Human Services Integration So Difficult To Achieve?” *Focus* 23, no. 2 (Summer 2004):35. Available at: <http://www.irp.wisc.edu/publications/focus/pdfs/foc232g.pdf>.

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